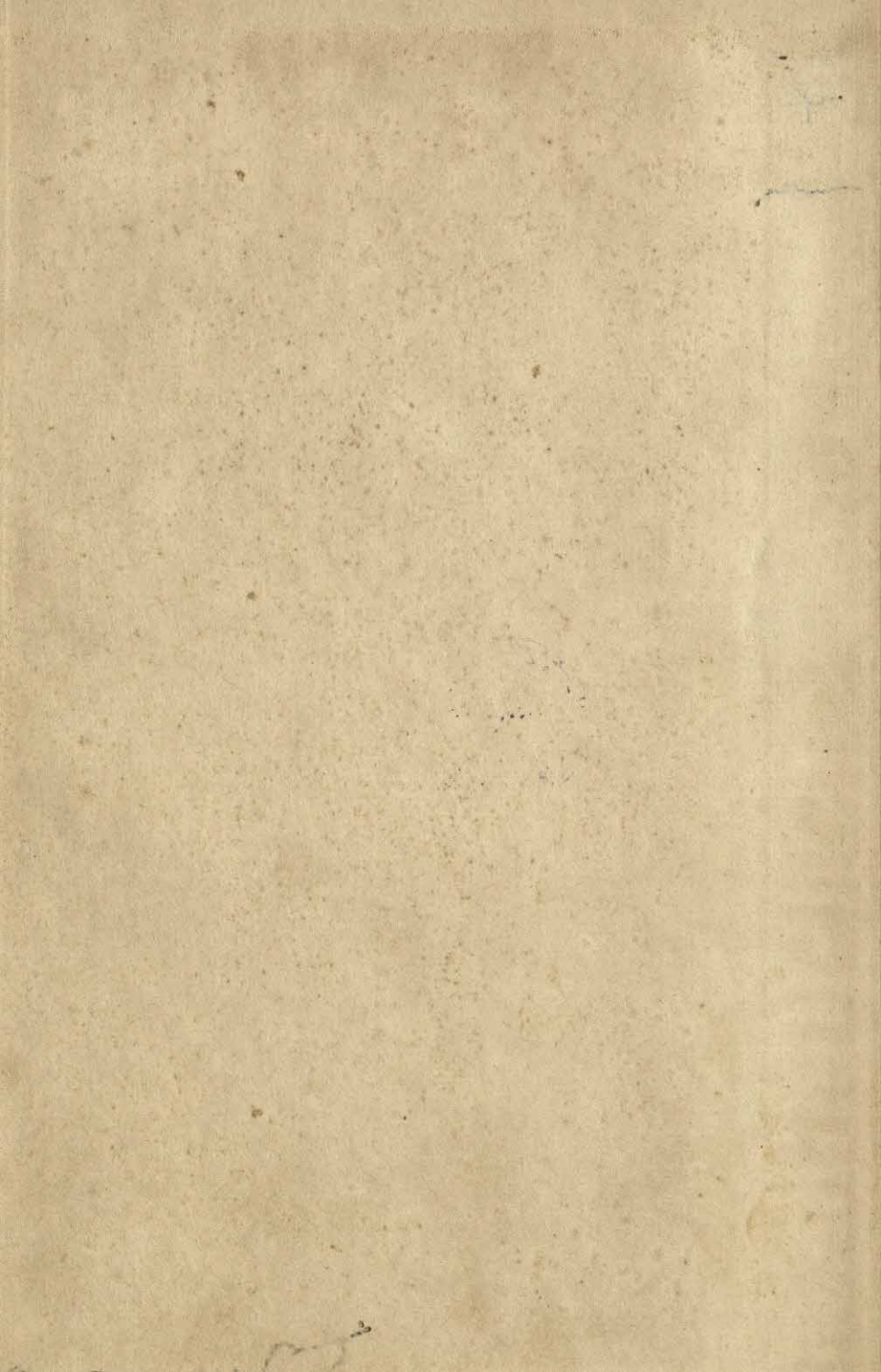
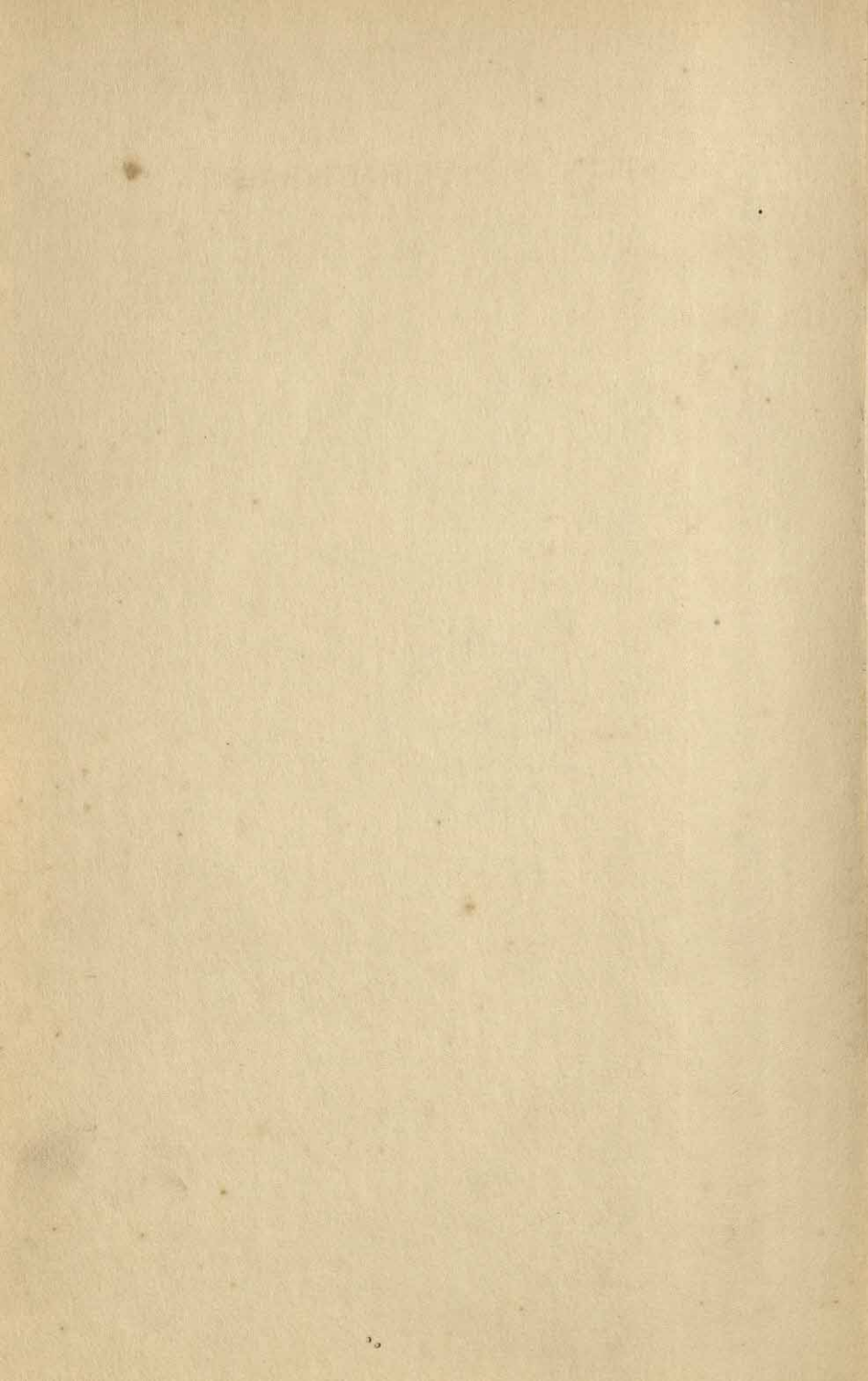

STEPS IN PSYCHOTHERAPY







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STEPS IN PSYCHOTHERAPY

Study of a Case of Sex-Fear Conflict



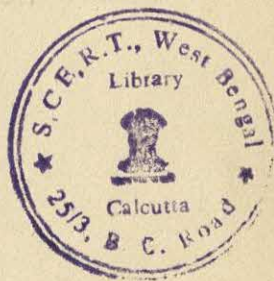
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TO

Robert M. Hutchins

Milton C. Winternitz

and

James R. Angell

Founders of the Institute of Human Relations at Yale

OTHER BOOKS BY JOHN DOLLARD

Criteria for the Life History

Caste and Class in a Southern Town

Frustration and Aggression (with R. R. Sears, O. H. Mowrer, L. Doob,
and N. E. Miller)

Children of Bondage (with Allison Davis)

Victory over Fear

Fear in Battle

Social Learning and Imitation (with Neal E. Miller)

Personality and Psychotherapy (with Neal E. Miller)

PREFACE

Freud wrote in a letter to J. H. W. van Ophuijsen, "I would advise you to set aside your therapeutic ambitions and try to understand what is happening. When you have done that, therapeutics will take care of itself." We have tried to follow Freud's advice.

Freud's writings have contributed fundamentally to the basic theory of therapy used in this book, yet the case we present is not a test of psychoanalytic theory or practice. In particular, dream material and recovery of childhood memories are given scant attention. In brief psychotherapy the treatment must necessarily center on the patient's immediate problems.

As illustrative material we offer seventeen hours of a therapeutic case. We try to show the steps in the development of this case with a view to defining new units of analysis. We show also some aspects of the training of an apprentice psychotherapist to the end of illuminating this activity.

Our therapeutic techniques are based on theory advanced by Dollard and Miller. This theory is a blend of a reinforcement learning theory and psychoanalysis, with Freud, so to say, providing the power, and learning theory the precision.

We address *Steps in Psychotherapy* to the students, teachers, and researchers in the fields of personality adjustment, abnormal psychology, psychotherapy, social work, psychiatry, counseling and guidance. We think it also of some pertinence to that circle of intelligent adults who keep up with new things in the science of human personality.

At this time, when the Institute of Human Relations is disappearing as a collaborative research enterprise, we want to say that we think it the best thing of its kind that has existed or will exist until a new enterprise with the same principles is created. The many imitators of the Institute have never reproduced its vital organs; its steady behavioral heart, its cultural lungs, its Freudian guts. We therefore gratefully dedicate this book to the imaginative founders of Yale's Institute of Human Relations: Hutchins, Winternitz, and Angell.

We are most grateful also to the New York psychiatrist who must remain anonymous so that the identity of one of his patients can be completely protected. Not only did he give us permission to use his case material but also the transcriptions of the supervisory sessions in which he received training.

Many colleagues have contributed directly and indirectly to the publication of this work. Dr. Leonard D. Eron, Dr. Jules D. Holzberg, Dr. Richard Newman, Dr. Fredrick C. Redlich, and Dr. Seymour B. Sarason have been helpful at various times and in various ways. Among colleagues, Dr. Neal E. Miller is in a class by himself. The frequent references to the joint work of Dollard and Miller show better than any formalities can how much we are indebted to him.

We are grateful to the Institute of Human Relations for prolonged support of our research and especially to its Director, most permissive of administrators, Dr. Mark A. May.

We acknowledge with appreciation the help of Mrs. Margaret Toohey who assisted in typing the manuscript of this book.

John Dollard
Frank Auld, Jr.
Alice M. White

New Haven, Connecticut

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PART I

GENERAL PRINCIPLES

THEORY OF THE ARTS

CHAPTER I

OF THE NATURE AND SCOPE OF THE ARTS

THE ARTS ARE DIVIDED INTO TWO CLASSES

THE LIBERAL ARTS AND THE MECHANICAL ARTS

THE LIBERAL ARTS ARE THOSE WHICH ARE

NECESSARY TO THE CULTURE OF THE MIND

THE MECHANICAL ARTS ARE THOSE WHICH

ARE NECESSARY TO THE SUPPORT OF LIFE

THE LIBERAL ARTS ARE DIVIDED INTO

THE ARTS OF LIBERAL EDUCATION

AND THE ARTS OF MECHANICAL EDUCATION

PART II

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THE HISTORY OF THE ARTS IS DIVIDED INTO

THE HISTORY OF THE LIBERAL ARTS

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THE HISTORY OF THE LIBERAL ARTS IS

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PART I

THE HISTORY OF THE

AMERICAN PEOPLE

The history of the American people is a story of growth and development. It begins with the first settlers who came to the New World in search of a better life. These early pioneers faced many hardships, but they persevered and built a new society. Over time, the American people have grown in number and in power, and they have made many contributions to the world. The story of the American people is a story of hope and achievement, and it is a story that continues to inspire us today.

The American people have a rich and diverse heritage. They are descended from many different peoples, and they have brought with them many different customs and traditions. This diversity has been one of the strengths of the American people, and it has helped them to build a nation that is truly unique. The American people have a strong sense of community and of shared values, and they have a deep love for their country. This love and this sense of community have helped them to overcome many challenges and to build a nation that is free and just.

The American people have a long and proud history, and they have many achievements to be proud of. They have built a nation that is the envy of the world, and they have made many contributions to the progress of humanity. The American people are a people of great courage and of great faith, and they are a people who are always ready to face the challenges of the future. The history of the American people is a story of hope and of achievement, and it is a story that continues to inspire us today.

BRIEF PSYCHOTHERAPY: Its Aims and Strategy

Psychotherapy is one of the most remarkable of modern innovations. Unknown until sixty years ago, it has thrown light on the long-standing mystery of neurosis and on the nature of normal mental life as well. Poets and philosophers have assured us that the highest human goal is the understanding of human personality. If such is the case every civilized man ought to want to know something about the findings and methods of psychotherapy.

WHAT IS PSYCHOTHERAPY?

To answer this question one must first pose a prior question: What is neurosis? The facts about neurosis seem to be these. Some people come out of childhood with an impairment of mental life and an inhibition of power to act in critical life areas. In early years neurotic persons had been frightened out of their capacity to think, love, and work at a high level. Subjected to adverse conditions, they learned¹ bad habits of not thinking straight and not acting effectively. Consequently they are unable to relate themselves in a cooperative way to other persons. Both the mental impairment and inhibition of action of neurotics are due to emotional conflict.

¹ There are four necessary conditions of learning: cue, drive, response, and reward. To put the matter in ordinary language, a person must see something, want something, do something, and get something if learning is to occur. Any response that is followed by reward is strengthened, i.e., will be more likely to occur the next time that the individual is in the same situation and impelled by the same drives. For an extended statement of learning principles the reader is referred to Dollard and Miller (1950).

The inability to think about important problems makes the neurotic seem *stupid*. The pressure of conflicting drives makes him *miserable*. *Symptomatic acts* somewhat, but only partly, reduce his misery. The neurotic is thus strangely incapacitated, unable to describe his past, unable to cure himself, and unable to act effectively in the real world.

✓ The business of psychotherapy is to correct the bad mental and emotional habits the neurotic has learned. Since new habits can be learned only under new conditions, a new learning situation must be created. This the therapist proceeds to do. To begin with, he has the prestige of a specialist. He sets up a warm, permissive atmosphere, different from that to which the patient has formerly been exposed. The therapist encourages free expression on the part of the patient. He does not judge or condemn. Temporarily the therapist becomes an important person in the patient's life. The patient's tendencies to love and hate are transferred to the therapist and are clearly exhibited in the relations between the two. The study of this relationship gives the therapist essential information. Throughout the relationship the therapist stands for reason and reality. The therapist thus gives the patient an experience more benign than any he has had before.

The therapist is more than permissive about free speech. Indeed he urges the patient to say everything that comes to mind. He pits this urgent requirement against the patient's reluctance to speak his thoughts.

As the work proceeds, the patient fearfully recites his thoughts and intentions and awaits the thunderclap of disapproval which he has learned to expect. When it does not come in the course of repeated trials, his fear is extinguished, and the once frightening sentences lose their power to create alarm. As fear is reduced, new thoughts can occur, especially those which have formerly been opposed by anxiety.

LABELING AND DISCRIMINATION

When the patient cannot find words for the strong tensions which beset him the therapist offers them. We call it "labeling." Thus words and sentences are attached to emotions formerly repressed. It comes as a great relief to the patient to have a complete and correct account of his own inner experience. Through the provision of new labeling the patient can be said to become emotionally intelligent. He is made capable of dealing with his conflicts at the mental level. For the first time he

can anticipate problem situations and act with foresight in important areas of his life.

The neurotic person lives in a fog of confusion. He still anticipates punishments which could only be imposed in childhood. Here the therapist can help by aiding the patient to make discriminations. He separates imaginary fears from real ones. Emotions and courses of action for which the patient was once punished can be shown to be no longer punishable. By contrasting life conditions of the past with the present, the therapist can show that courses of action which would once have been dangerous can now be not only not dangerous but positively rewarding and essential to life. The patient can be reminded that though once small and mentally helpless he is now grown and mentally capable.

As fear is reduced by extinction and discrimination, as new labeling units become available, the patient in therapy tries out new solutions at the mental level. Extinction of anxiety and discrimination between dangerous and benign situations generalize quietly to the persons and situations of daily life. As this occurs, responses formerly inhibited can be tried out.

PSYCHOTHERAPY AND REAL LIFE

The result of the new learning in the therapy sessions should be a change in the real-life behavior, a fresh try, as it were. We hold that successful experience involving other people is essential to therapeutic effect. If the real-life situation is favorable, the responses newly tried out are strongly rewarded. Thus new habits are formed in the critical spheres of sex and love, self-assertion, independence, and self-confidence. If the real-life situation is unfavorable such benevolent results cannot occur.

Moreover, the effect of strong rewards is much more general. Reward effects extend backward from the successful goal acts and strengthen the labeling habits and action tendencies which led to reward. The indirect but important result is an intensification of mental life and increased ability to work out his own solutions to problematic situations. The neurotic comes to seem less stupid and unpredictable to other people. The reduction of basic drives, formerly inhibited, reduces misery and develops hopeful attitudes. The minor escape provided by symptoms is no longer needed as the capacity to love and work is restored.

In short, when these effects occur repeatedly the neurotic becomes no longer neurotic.

This account is necessarily swift and schematic. The therapeutic process is actually quite complex with many effects occurring at the same time, with many periods of pause and resistance, many errors, and moments of triumph and relief. Nevertheless, we believe it to be a useful sketch of the lawful relationships involved.

In this book we shall present a case which is designed to show how the foregoing principles are applied in actual therapeutic work. The seventeen hours of a case constitute a venture in *brief psychotherapy*. We shall now discuss in what ways a briefer effort differs from a more extended or intensive kind of therapy.

BRIEF PSYCHOTHERAPY DEALS WITH IMMEDIATE PROBLEMS

By brief psychotherapy we mean that which can take place in about six to thirty hours of contact between patient and therapist. Calling therapy "brief" does not change any of the psychological fundamentals of the therapeutic relationship. It means that only a limited attack on a total therapeutic problem can be made. If this suffices, the brief psychotherapy is successful and if not, it fails.

The briefer effort must necessarily deal with everyday things. By this we mean that it deals with the results of past conflict situations as they are seen in the most obvious behavior of the patient. How is his life today distorted by what has happened in the past, even though one does not know very clearly what did happen in past times? What are the simplest things the patient needs to learn? What are the most evident forms of repression and inhibition which are stopping him from trying the responses that would be adaptive? These are the questions to be asked. By empathic rehearsal of the patient's story, and comparison with common-sense standards of action,² the therapist picks out the habits which most obviously interfere with a tolerable life adjustment.

The therapist should react to the immediate cues of what the patient is doing in the therapy situation. Searching for a life history may take attention away from the best datum the therapist has—which is the patient's current behavior. The patient's behavior is organized around his

² Alas, these standards are not very well defined, but it is certain that every therapist has and uses some such common-sense standard.

neurotic conflicts, and the therapist should react to this immediate behavior. He should try to see the patient's conflict as exposed in the current situation. If a woman patient cries and asks the therapist to tell her what to do, he does not need to be told that she has had a domineering parent; he sees in the patient's weeping and pleading that dependent traits have been rewarded. The therapist knows what a person might properly be expected to do in the interview situation if motivated, honest, intelligent, and able to give a clear account. The cue to the therapist is the difference between what a person might be expected to do and what the patient does.

In asserting that brief psychotherapy must deal with current problems we do not deny that something vital is lost if the therapist does not understand the patient's history. A knowledge of the past can be used to convince the patient that he is different from other people and that there are good reasons why he should be. This knowledge of difference tends to excite motivation to complete the therapeutic work. Furthermore, the life history provides a detailed account of the circumstances under which present neurotic habits were first learned. If the threatening and despair-producing circumstances of the past can be contrasted with the more propitious situations of present-day life, the patient can make a discrimination which reduces fear and increases hope of benefit from therapy. Nor is this all. In the sphere of the love life, each patient will come forward with a unique combination of learned appetites and fears—what Freud calls the "conditions of love" (1925, Vol. IV, p. 192). The life history will serve to show just what drives and fears were learned and how they were learned. With this knowledge, the present-day conflict of the patient can be much more exactly defined and appropriate measures of extinction, discrimination, or reassurance introduced. Therefore, a precision job of psychotherapy requires a good deal of knowledge about the patient's past life. In discussing the task of brief psychotherapy we are not suggesting that such knowledge of the past can be dispensed with. We are asserting that something can be done in brief periods of time, but that it will be a much less thorough and final job than more extended therapy would make possible.

As a practical matter, there is little doubt that what seem like small gains in insight to the therapist can be of considerable importance to a patient in brief psychotherapy. Knowing that he is not alone, that he has someone to whom he can turn, may be of great help. Sensing that he is

not condemned, that someone is willing to accept him with neutral benevolence, may be important. Learning that everyone has a problem, that he is not especially picked on by fate, can be useful.

At present we can only be sure that some people do gain something from brief contacts. Communication of a word or an attitude can have a profound effect if it is just the loan of this word or attitude that is needed to solve a problem. However, we know also that many people subjected to brief psychotherapy do not get what they need and cannot get it under these circumstances.³ They must necessarily be thwarted.

UNCERTAINTY AS TO BEST TECHNIQUE

There is but little information on the best techniques and circumstances for brief psychotherapy. One thing is certain: some preliminary information is necessary for a rough screening of patients. Psychotherapists do not want to spend time trying to treat patients who cannot benefit at all from brief psychotherapy. The therapist has to make some kind of estimate as to how strongly the patient is motivated for treatment, how fast he can learn, and how much anxiety he can bear. Is his difficulty recent and provoked by severe situational factors or is it overlearned and of long standing? How much realistic opportunity does he have to try out the new responses which might be adaptive? The therapist must consider such matters in accepting a new patient.

Of course, we do not mean that quantity of information about a patient has an automatic therapeutic effect. It seems rather more likely that information in excess of the schematic type needed to diagnose may be wasteful or even harmful. Instead of seeking additional information the therapist would do better to concentrate on the nearest obstacle to the patient's communication in the therapy. In the case of Mrs. B.,⁴ the patient wanted to keep the treatment a secret from her husband. Why? Here is the nearest conundrum. Let us examine it more carefully and see what the patient says about the matter of secrecy. This may be the door through which a significant entry into important problems can be made. At this point excessive information may even be a handicap in that it may suggest constructions which take attention off the all-important canvass of immediate barriers to communication. Information may thus confuse rather than orient.

³ Gill (1951, pp. 69-70) has called attention to the limitations of brief psychotherapy.

⁴ This case is reported in detail later on.

WHO CAN PROFIT MOST FROM BRIEF PSYCHOTHERAPY?

As we have said, the best conditions and techniques of brief psychotherapy have not been adequately determined,⁵ but so far as our experience goes we would suggest that some of the factors are these: Younger people have a better chance of benefiting from psychotherapy because they are less committed and have fewer crucial decisions behind them. Married people are a better risk because, if sex is a problem, they have a situation in which sex responses can be practiced with the full approval of the community. People with a demanding occupation are to be preferred as patients because they are seriously engaged in life. They have more to lose from failure and more to gain through better adjustment efforts. Furthermore, the occupation provides a real test for the person's ability to be appropriately competitive and offers a field where newly learned assertive responses can be tried out. Socially mobile people should be better risks because of the strength of motivation to succeed in real life. By contrast, the "endowed" patient should have more difficulty in learning the new habits needed.

We believe, further, that patients with strong normal sex appetites (even though repressed and inhibited) should have a better chance to gain from brief therapy. It is difficult to set up circumstances for training sex appetites. If they already exist, they are a source of positive motivation for therapy even though temporarily inhibited.

The therapist who treated Mrs. B., for example, could utilize the strong sex motives of this patient. As the informed would expect, a sex conflict played an important role in the life of this hysterical patient. She evidently came out of childhood with well-developed sex appetites which were, in turn, opposed by strong fear reactions. The occurrence of a severe sex conflict is not uncommon. Sex is the primary drive most opposed by social taboos. Strong punishments are attached to its expression in childhood and a long period of waiting is forced upon the individual before drive expression is possible.

If one has to choose among conflicts, the occurrence of a sex conflict

⁵ Knight (1949, pp. 109-110) has made a helpful summary of the "special indications and contraindications" for brief psychotherapy on the basis of his personal experience as a therapist. Alexander and French (1946, pp. 96-106) also have recommended some practical criteria for the treatability of patients.

is not altogether deplorable. A well-marked sex appetite is a positive force. It gives the therapist something to work with. If the patient has a weak sex appetite or none at all, as we surmise might sometimes be the case, his "grip on life" is by so much weakened. Strong sex appetites can be disciplined. But, as we have said, it is very difficult to develop these appetites, if they do not exist—at least in the therapeutic situation. After all, the specific form of human sex habits is not innate.⁶ Human beings must learn their sexuality. If patients are motivated sufficiently so that they can be put in a severe sex conflict, there is the hope that reducing fear attached to sexual impulses will allow the latter to emerge as a positive force in their lives.

We might say also that patients without confusing organic difficulties probably have a better chance in psychotherapy. Physical symptoms are the commonest and strongest of all defenses. Where there is a real possibility of an organic cause of the disorder and the organic factor cannot be definitely excluded, the therapist can never flatly define the problem as neurotic and get the patient to address himself exclusively to its psychological features.

There is a second group of excuses which are frequently used to hide the real neurotic conflict. They may be called sociological. The neurotic wife finds her club work too exhausting. The children may prevent her, she says, from acting like a wife. Again, a woman may allege that the role of minister's wife is too taxing and that this is the reason for her neurotic illness. In the saddest cases, depressed standards of living and overwork or a life of failure may seem to account for all of the misery which the neurotic experiences. These sociological excuses must be discounted if the patient is to be got to address himself to his neurotic problem. The easier it is to show that the life situation could not account for the neurotic symptoms, the easier it is to get the patient to face his psychological problem and attack it wholeheartedly. The more adequate the sociological excuse, the more difficult to get at the neurotic problem. If, however, the sociological excuses can be discounted and given only their true relevance, the therapist will be able to show his patient that he clings to a sociological theory of illness in order to avoid considering the neurotic conflict itself.

The reader may well think that if a patient had all the assets and lacked the disadvantages that we have been discussing he would not be

⁶ See Ford and Beach (1951).

likely to be neurotically sick and seeking treatment. This is not the case. A patient can be young, married, involved in a demanding job, socially mobile, without organic disorder or extreme sociological circumstances and still be neurotic. We give this summary list on the possibility that therapists must select patients and that it may be advantageous, with limited time, to select those most likely to profit. If a therapist does not make such a selection he may waste *all* of his time.

THE INTERACTIVE EPISODE: A Tentative Way of Dividing Psychotherapy into Natural Units for Scientific Description

Everyone has a "story," a preferred view of himself and his relation to his environment which he holds out to others. One's friends are those who are able to consent to this story. In the case of normal people, the story matches reality at all or most critical points; but in neurotic persons serious discrepancies occur between their "cover story" and the facts of the case. Ordinarily a person's story is not challenged. However, if life events do explode the fictive narrative of the neurotic person, the results can be disastrous—personal demoralization, suicide, or mental disorder.

The patient who comes to psychotherapy does so on the implicit understanding that his story can be challenged if it is at odds with real events. In fact, psychotherapy may be viewed as a situation in which the patient gets a chance to change his story—though slowly and with time to learn. The patient has tried acting on an unrealistic or contradictory concept of self and environment and has found that he could not achieve what he wanted. Acting on the incorrect account has produced strong motivation, which is part of the "misery" of the neurosis. The misery of conflict and dammed-up motives can be used to make the patient cooperate in the therapeutic situation. With the help of the therapist, he acquires a more realistic account—one which better predicts the real rewards and punishments of his environment. Guided by this more valid appraisal of the environment and having had the oppor-

tunity to try out new verbal and emotional responses in the therapy relationship, the patient tries out more adaptive habits in his relationships outside. Of course the patient's new story is not consolidated and maintained unless it is reinforced by real-life rewards.

THE PATIENT'S "STORY"

The particular story that a patient brings to therapy is, of course, not an accidental matter. It is not, for instance, lightly borrowed from someone else. Rather, it is a set of statements about himself which make him maximally comfortable or, put in another way, arouse least anxiety. When the therapist doubts the story, he brings a new force into play. He tells the patient that his story somehow does not check out logically or that it does not correctly describe the environment. These statements or doubts of the therapist create motivation in the patient—a motive to make his story logical and realistic. The patient thus motivated tentatively adopts the doubts of the therapist. These doubt responses compete with the unrealistic response elements of the patient's story.

IMPORTANCE OF THE SELF-DIRECTIVE DRIVE AND THE EGO

The patient's mental activity in seeking a logical and realistic account of his own behavior is part of what analysts call "the Ego." The correct analysis of total Ego activity from a behavioral standpoint will undoubtedly be a task of some magnitude. We cannot attempt it here, but we would like to point out one Ego motive that is of great importance both in neurosis and in therapy. This might be called a self-directive drive or motive. When operating, it sometimes has the negative effect of making the patient resist appropriate dominance or limitation by another. On the positive side, it could be called a motive for independence or autonomy.

In conjunction with the drives to be logical (to have an uncontradictory account of the world) and to be realistic (to describe the environment accurately), the self-directive drive plays an important role. This motive is mobilized by any threat to autonomy from within or without the body. The occurrence of delusions or hallucinations may activate the autonomy motive. The patient asks, as it were, "What uncontrolled, perhaps dangerous, processes are occurring within me?" The occurrence of unaccountable misery or strange appetites likewise arouses the

self-directive drive. We can see its results in the great tension produced by fear of insanity. To be insane implies that in the judgment of others one is no longer capable of self-direction and correct estimate of the environment. Fear of loss of autonomy appears as a piteous concern in the early manifestations of mental illness in many cases. The question, "I'm not going crazy, am I, Doctor?" is familiar to all psychiatrists.

Perhaps this fear originates in childhood. The person dreads to be put back under the seemingly arbitrary authority of the childhood period. He fears to be restored to child status, physically weak, unable to manage his own affairs, and poor in reality discrimination and judgment.

So far as therapy is concerned, the autonomy motive often appears as an interfering factor. Under this compulsion the patient may refuse to admit his illness and therefore his need for help. He may insist on fighting it out in his own way, though all experience shows that he is constantly losing the battle. Proud and resistant patients experience a great relief when they are able to understand the therapeutic situation as one which they can partly manage and control. Realistically recognizing illness, they use the therapist as a means of self-help. In this way, the motive to be master in one's own psychological house can help the patient keep on making the difficult responses required of him in the therapeutic situation. Though important, this motive is but one aspect of all that is usually included under the Ego concept.

HOW THE THERAPIST HELPS MOVE THE CASE AHEAD

The changes brought about in therapy are a result of genuine interaction, or interstimulation between patient and therapist. There is nothing one-sided about the transaction. The patient, on his part, labors to give a complete and truthful account of his life. If the patient accepts the rule of free association, he will find himself attempting such an account. In the beginning of therapy his account cannot, in fact, be either complete or entirely truthful, but it is the patient's best attempt.

The therapist, on his part, gives his deep and complete attention. He mentally rehearses the patient's story and, as he does so, notes gaps, contradictions, defensive overemphasis, and other evidences of a distorted account. These cues enable the therapist to respond usefully. He intervenes because if he does not, nothing will happen in the therapy.

Patients returning after intermissions of months or years are found to be suffering from the same conflicts they had when therapy stopped. It is clear that the therapist must somehow, and constructively, intervene. Of course, the therapist usually does this in the least authoritarian way possible. He simply says he doesn't understand the patient's account when it is not intelligible. The therapist thinks there must be more to it. He is just plain puzzled. He points out conflicting elements. He indicates attitudes, once adaptive, that are no longer so. He designates emotional reactions that are occurring but are not labeled.

Thus bestirred, the patient tries again. He brings out new facts and new emotional responses. The sequence that begins when the therapist notes evidences of distortion or incompleteness in the patient's account and ends when the patient brings out new facts and new emotional responses, we shall call an *interactive episode*.

Interplay between patient and therapist goes on from episode to episode. The episode often begins with a question and ends with an answer that poses a still further question. From one standpoint, the speed of therapy thus depends on whether the patient and therapist hit on the right episodes. If they never do, presumably no therapy (in the sense of increased psychological well-being) could occur.

It is easy to overestimate the role of the therapist in this transaction. If the patient is not genuinely cooperating, not really reacting, the therapist may be ever so skillful, ever so puzzled, and still nothing will happen. The patient must be vigorously attempting to get his story straight if therapy is to occur. If he is unable to make this vigorous attempt, no psychotherapist can help him. We believe, however, that the basic unit in therapy is the interactive episode. The conditions which make it possible and creative must be closely observed.

MENTAL AND EMOTIONAL LIFE

We have described the activity of the patient in psychotherapy as "mental." His labor to give a complete and correct account of his life, his attempts at revising this account, when gaps and inconsistencies are noted by the therapist, are mental in a broad sense of the word. For some people, however, mental may be a misleading term. What we call mental life is not merely intellectual. It also involves strong emotional

responses. We have sometimes toyed with the thought of coining a word like "mentemotional life," to emphasize the importance of emotional drives and cues in the mental transaction. The term is so awkward, however, that we do not use it.

We used to say that mental life consists of lines of sentences running parallel to major environmental events, both internal and external. We no longer say this. Mental life is not thus carefully separated from emotional life. The close connection between the two is perhaps well implied in the words "imagination" or "imaginative." We wish to emphasize, therefore, that the cues produced by words and sentences are linked to emotional responses which can, in turn, be linked to verbal responses. Both learned motives and learned rewards play an immense role in the mental sphere.¹ The therapist's capacity to evoke learned motives is the most powerful of his tools.

THE ROLE OF THE THERAPIST

We were tempted to refer to the therapist as circling around the embattled patient as an army might circle a citadel awaiting the moment of attack. Metaphors, however, have a way of misleading. The real transaction is not very much like capturing a citadel. The therapist does not attack, and the relationship between patient and therapist is not one of battle. It is true that there are resistant forces operating within the patient which make it difficult for him to cooperate as he would like to do; but it is equally true that there are strong cooperative forces within the patient which keep him trying and proceeding with therapy.

It is not correct, either, to say that the therapist challenges the patient's story. Rather, the therapist expresses doubt which produces the motive that impels the patient to challenge his own story. The role of the therapist is more that of prompter than of interpreter. But unlike the unseen prompter of the theater, the therapist only tentatively suggests what the true lines of the patient's script of life might be.

To say that the therapist interprets implies that he may capriciously put some favorite construction of his own on the patient's statements without regard to the facts and the patient's needs. Actually we believe just the opposite. The patient is dominant in the situation in that it is his problems and defects which are to be explained and repaired. His

¹ See Dollard and Miller (1950, pp. 62-94). The work of Neal E. Miller also is basic to our theories. Relevant recent publications are Miller (1951a) and Miller (1951b).

life is the focus of mutual attention.² The therapist is trying to find and lend to the patient the "right" sentences to describe his life.

THERAPIST IS REPRESENTATIVE OF SOCIETY

He is further trying to give the patient in therapy a direct experience with a "decent" representative of society. The therapist is indulgent of trifles, errors, and failures resulting from the patient's faulty training in the past. In addition to giving him a corrective contact with an emotionally intelligent representative of society, the therapist helps the patient to find a correct account of his experiences. Both the *correct* account and the *exemplary* experience are needed to produce a profound therapeutic effect. On the intellectual and emotional level, the therapist prompts; on the experiential level, he tries to show directly how a decent person would behave in the face of the failures and suffering which the patient reports.

Where the patient has been accustomed to arbitrary treatment, he finds that the therapist's behavior is based on a reasonable theory of how to benefit the patient. Where he has been accustomed to opposition or condemning silence in regard to sexual thoughts and motives, in therapy he is urged to communicate. Where the patient is accustomed to counteraggression, he meets tolerance and inquiry as to the cause of anger. Where the patient has been led to expect reinforcement of fears, he is offered a rational analysis of what is to be feared and what not. Where he has been condemned *in toto* for a single fault, in therapy he finds a discrimination made between his strengths and weaknesses, and he gets full credit for the positive. Where he has told his troubles to heedless ears and preoccupied minds, the therapist responds to him with an intense, empathic listening. Where the patient is accustomed to acceptance of inaccurate and rationalized accounts of his behavior, he meets discriminating doubt and steady realism. It is in the course of these experiences that new emotional habits are learned and a correct account of the patient's faults and needs is evolved.

In the very nature of the therapeutic relationship the patient is committed to the task of revising his cover story and resolutely, if not wholly gladly, he tries out the suggested revision. Our goal will be, therefore,

² This view of the therapeutic relationship is in accord with that of Rogers (1951, pp. 26-30). We would, however, like to see both the patient's and the therapist's roles analyzed in detail.

to show how therapy occurs by giving a strict stimulus-response account of the interpersonal situation and the new labeling which it produces.

AN EXAMPLE OF THE INTERACTIVE EPISODE

An interactive episode begins with the therapist's discovery of some illogical, incomplete, or contradictory aspect of the patient's story. Not to be too darkling about this matter, let us take an example from a case that will be analyzed in detail later on in this book—the case of Mrs. B.³ In the early hours of treatment, she stated her problem as discomfort about aggressive feelings toward her mother. The wish to aggress was based, according to Mrs. B., on the fact that her mother “stole her children.” It appeared that her mother had indeed taken care of Mrs. B.'s daughter who was slipping away from her authority, defying her, and preferring the grandmother. Mrs. B. complained also that the grandmother bribed the children.

The therapist sensed something incongruous in this account. He knew how greatly our society respects the mother-child tie. (Linton, 1952, p. 69.) He believed that it would have been impossible for the grandmother to “steal” a child if the mother had been making a serious attempt to keep it. He therefore reacted to Mrs. B.'s statement with a certain degree of “stupidity.” He could not quite understand how it was possible for the grandmother to steal the children as alleged.⁴ By this failure to understand, he raised a new thought—to wit, if the account as given does not explain the situation adequately, there must be something missing from the account which, if present, would explain. It turned out, indeed, that there was something very much missing from the first account—namely that Mrs. B., as a result of her own severe conflict about motherhood, had rejected and deserted her children. She had, so to say, *left* them to the grandmother. It may have been that the

³ If a reader would like to try out his skills in interpreting the projective tests which were given to this patient before she began psychotherapy, he should stop at this point and turn to Chapter 10 so that he can read and interpret the test materials. Unless the reader attempts this before he is exposed to other information about Mrs. B., he cannot avoid getting cues from the case materials that influence his interpretations of these tests. In order to make analysis of the tests a real trial of the interpreter's skill and of the adequacy of his hypotheses, his interpretation must be independent of any extraneous information. This is especially necessary because test interpretation falls so far short of being objective.

⁴ Such a thought can easily be conveyed by a doubting repetition or paraphrase. It is nevertheless an intervention.

grandmother was a little more than ordinarily ready to accept responsibility and take advantage, but it was profoundly true that the grandmother's action would not have been possible had Mrs. B. played her mother's role in the conventional way.

As soon as Mrs. B. understood the relation of her own behavior to the loss of her daughter, there was no longer a problem of aggression against her mother. The problem became not how to retrieve her child by justified aggression against her mother but rather how to explain her own rejection and desertion of the child. The emergence of the new problem ended the "episode" of the old. The discussion took a new turn. It started off in unexpected directions, as a reading of the case will reveal.

It will be evident in the report of Mrs. B.'s hours of therapy (in Chapters 4 through 6) that some interactive episodes may be short, others long. Moreover, a resistant response that has been once dealt with by the therapist may reappear when competing responses have been weakened. The therapist indeed may have to deal with the same resistant response several times. Although episodes may differ in length and resistant responses may reappear, nevertheless as the case progresses it falls into a succession of natural units—*interactive episodes*.

THE SEQUENCE OF INTERACTIVE EPISODES

There are two problems in analyzing the case material: (1) how to fragment the data, that is how to identify the resistant behavior and the therapist's responses; and (2) how to account for the movement from episode to episode in logical sequence. The general direction is from outside to inside, from environment to psychological structure, and from projection to self-blame or self-examination.

The order in which interactive episodes occur in a particular case will, of course, result from the life history of that patient. The patient comes to therapy with a set of rewarded escape responses which are arranged in a kind of hierarchy. These responses (opinions, beliefs) appear in therapy as resistances. As the top member in the hierarchy is made untenable, the next strongest member appears.

Of course one resistant statement may be logically prior to another. For instance, Mrs. B. could not blame her husband for the failure of their sex life when she was insisting that their sex life was satisfactory. Nor could she notice her own strong sex inhibitions while she was

projecting blame for sexual failure on her husband. There is therefore some logical sequence in the occurrence of interactive episodes. But movement through this sequence is not automatic. The therapist must "play opposite" to the patient by expressing doubts and realistic thoughts.

The therapist does not impose his ideas on the patient. He has to use the patient's own motives to be logical and autonomous in order to get him to change—even to change to another resistant statement. Thus the episode is patient-centered as well as interactive; and patient and therapist together must hit on a correct account of what is going on.

CONCERNING THE MEASUREMENT OF PSYCHOTHERAPY

The exploratory work on what happens in psychotherapy has not yet been properly done. This fact makes measurement difficult. Exploratory work should line up the problem and pick out the main variables in a crude way. So long as many units of the basic problem are undesignedated or unsuspected, it is difficult to conduct a rational measurement operation.

Progress in measuring therapeutic results may now be slow because the problem has been so poorly put. For example, it may be necessary to learn how our patients learn to speak in the first place before a rational theory of therapy can be developed. Perhaps the matter of how emotional responses are attached to the verbal cues may prove to be crucial.⁵ Furthermore, psychotherapy shares with many other fields the difficulty that there is no good criterion of success.⁶ Nor do we have a good ruler by which to decide how disadvantaged the patient is at the outset, how far he is from some sensible criterion. The trouble with measuring psychotherapy at the moment seems to be that therapists do not know what they are measuring, what are the subunits of the com-

⁵ Mahl and Karpe (1953) are pioneering in investigating the connection between the patient's verbal responses in therapeutic hours and a physiological symptom of emotional conflict, namely the gastric secretion of HCl. Lasswell (1937) used the galvanic skin response as a measure of "unconscious affect," and showed that as a successful case proceeded autonomic excitation decreased.

⁶ Hunt and Kogan (1950) have prepared a manual for measuring movement in social casework because of the recognized need for more adequate criteria of success in this field. See also Hunt, Blenkner, and Kogan (1950). Dollard and Mowrer (1947) had previously shown that "discomfort" and "relief" sentences in social casework records can be reliably counted and plotted graphically.

municative process which produce the end result, *therapy*. When we are able to measure therapy we will be able to measure a piece of it, as well as the whole process.

The pertinent variables must be found before measures can be invented. We have tried to picture this difficulty to ourselves in the following way: suppose we had the concept that our experimental animals were motivated but we could not distinguish the separate drives of hunger, thirst, sex, fatigue, and pain. We might have some success (but probably not much) in measuring the effect of motivation on learning. Without suspecting the variable of hunger we would be sometimes dealing with hungry and sometimes with satiated animals; similarly, for the other basic drives mentioned. Our trouble would arise from the fact that we would never be able to *manipulate* the motives because we could not identify them. We suspect that a confusion of this kind may actually be reigning at the moment in the field of psychotherapy. What is needed, then, is to state clear theory and test it piece by piece.

We have already suggested that the *interactive episode* may be a part of such a theory. An interactive episode is the period in which the therapy centers on a particular resistant act or opinion. Therapy moves from one episode to another as one resistant response is abandoned under the pressure of logical self-criticism and another one arises. In the course of dealing with these resistant responses the therapist gets more and more information about the conflict elements, escape from which is reinforcing the resistant thoughts. In later chapters we shall try to test this interactive episode hypothesis in a rough way in the case of Mrs. B.

IMPORTANCE OF KNOWING THE CASE IN DETAIL

If we are ever to understand how therapeutic effects are achieved, we must pay attention to the *detail* of the interaction between patient and therapist. We need a kind of histology of the psychotherapeutic transaction. Until recent times such an exact and detailed analysis has been impossible. But in recent years the lifelike recording of interviews has, for the first time, provided us with the indispensable facts. It is the close consideration of these facts that will get us forward in understanding what happens in psychotherapy and, incidentally, in estimating how much therapy happens. Very general before-and-after ratings of "improvement" or "movement" will not give us understanding of the therapeutic process.

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We need to itemize the kinds of interventions that the therapist makes. In the episode from the case of Mrs. B. discussed in the preceding pages, it was an intervention when the therapist "did not understand." It was an intervention when he believed and said, "There must be something missing." It was another intervention to doubt that a grandmother could "steal a child" as alleged. As we have elsewhere contended (Dollard and Miller, 1950, pp. 243-244), quiet permissiveness can itself be an intervention, for if the patient expects punishment, a permissive attitude reduces expectation of punishment and hence changes the strength of such expectation.

TWO SUGGESTED MEASURES

We are quite convinced that *psychotherapy* is conflict therapy. Its goal is to reduce the amount of primary drive chronically borne and to permit subdominant drive elements to find legitimate expression. The therapist attacks resistant phenomena because they mask—and therefore point to—basic conflicts. He teaches the patient labels for hitherto unlabeled emotions; he teaches the patient to discriminate hitherto undiscriminated stimuli. He tries to discover and reduce unrealistic fears, to help the patient abandon habits that are no longer appropriate to the patient's physical and social status. According to our theory of psychotherapy, these actions of the therapist in the long run produce a reduction in the intensity of the conflict and permit the learning of new, more adaptive habits.⁷

It is clear, therefore, that there are at least two aspects of therapy to be measured. One could direct attention to the patient's acquisition of new, more adaptive mental habits *during* psychotherapy, or to the patient's improved real-life solutions *after* psychotherapy. A measure of the first aspect of therapy would have to do with the patient's freedom to reason adequately and label fully. Psychotherapy would be viewed as a situation in which the patient is acquiring increasing skill in labeling and increasing practice in accurate reasoning. A measure of the patient's "mental freedom" or skill in labeling emotions would, at the beginning of therapy, diagnose areas of poor labeling and defective reasoning. As the patient's labeling became more inclusive and his reasoning more accurate, such a measure would show his progress. It

⁷ See the discussions of this point in Shoben (1949, p. 372) and Dollard and Miller (1950, pp. 196-197).

should be noted that the patient may also have to learn other things besides better mental habits of the kind we have just described. For instance, he may need to learn to attach emotional responses to new sentence units.

The other measure would be some kind of adjustment scale. This measure would have to do with behavior in the critical situations of real life, with the ability to solve inescapable problems and gain the common rewards of our culture. It would be a scale measuring reduction of conflict and increase in real-world satisfaction.⁸

It is not very likely that either of these measures can, at least to begin with, be invented by hitting upon some happy form of opinion questionnaire. The data will have to be produced in the course of actual therapeutic interviews and observations of action in real life. It may be that new therapeutic techniques or interpersonal probes may have to be introduced so that the facts are fully brought out before and during therapy. For example, tests like the picture-arrangement test of the Wechsler-Bellevue Scale may be useful for evaluating the efficiency of the reasoning of the patient about social situations. It may be that brief follow-up interviews should be held to measure aftereffects once the patient is discharged from the therapeutic situation. (This discharge could be based on evidence of better performance of the labeling and reasoning skill.) The judgments of the surrounding "others" can be useful if they really know the patient intimately. We cannot now say what measurement techniques are likely to prove most useful, but we do have the conviction that psychologists will most quickly discover useful measures if they are guided in their search by a clear theoretical formulation of what should be measured.⁹ If the concept of the interactive episode, which we are proposing, should fail to order the data of psychotherapy in a useful way, perhaps it will at least lead to a better solution.

⁸ Miles *et al.* (1951) have done pioneering work in this field by developing scales for occupational adjustment, interpersonal relationships, marital and sexual adjustment, and patient's insight into his neurosis.

⁹ Hilgard (Hilgard, Kubie, and Pumpian-Mindlin, 1952, p. 43) also stresses the importance of being guided by theory in designing studies of psychotherapy. He points out that studies that are designed within the framework of a theory such as stimulus-response learning theory are apt to advance understanding and not merely to confirm or deny some specific point.

NOTES ON THE SUPERVISION OF PSYCHOTHERAPY

In chapters 4 through 6 the reader will see that the supervisor played a considerable role in the treatment of Mrs. B. It is not quite true to say that the patient was treated by the supervisor "over the shoulder" of the actual therapist, but it would be justifiable to say something like that. After each interview the supervisor and the therapist listened together to a playback of the hour, discussed it, and planned for therapeutic strategy and tactics. Because the supervisor had such an important role in the conduct of the case, we believe it to be useful here to make some general remarks concerning supervision of therapy.

CLOSE SUPERVISION NECESSARY FOR INEXPERIENCED THERAPISTS

Careful coaching is crucial for all inexperienced therapists. Therapists with a low level of emotional conflict and a high ability at emotional calculation—usually those who have had the benefit of a personal analysis—will get much more out of careful supervision than those who have not gained this insight and perspective. In the latter case the supervisor may have to deal with emotional problems of the therapist as well as mere inexperience in therapy. However, both analyzed and naive therapists are likely to get lost in the early hours of their first cases. We believe that every therapist should have careful supervision in which a supervisor plays back the recorded hours of therapy and discusses the material point by point.

The traditional methods of supervision are entirely too loose. When the therapist, for instance, makes a summary weekly report of several hours of material to his supervisor, the supervisor never really knows what the therapist has done. Such a situation is ideal for repressions and distortions of report on the part of the therapist.¹ Simple forgetting is doubtless an important factor also. Furthermore, the therapist should get his stance set right at the beginning so that after his first hours he is practicing the right rather than the wrong habits. Only a sound technique can be the basis of brilliant practice and of capacity for useful innovation. Finally, not least of the advantages of careful supervision is the protection which it provides for the patient. It seems to us that the patient—any patient, private or clinic—has a right to have a therapist who is well trained from the outset.

The first case is never easy for the apprentice therapist regardless of the level of his prior training. It is probably easier for him to challenge logical inconsistencies and note gaps than to identify transference manifestations. For this reason, the supervisor is most helpful in the study of the relationship between patient and therapist. The novice therapist begins with the wrong worries. He faces his early sessions worrying about what to say instead of noting what is happening in the relationship between him and the patient. He should be thinking from the outset: What are the forces that are stopping the patient from talking? What is blocking progress of the treatment?

When the patient is blocked severely there is usually some transference aspect that is keeping him from talking pertinently. Perhaps he is suspicious of the therapist's discretion. Perhaps he is strongly attracted to the therapist but also afraid to show his feeling. Perhaps he is holding out and feels guilty and expects punishment for this action. Such manifestations will bewilder the beginner. He will react unconsciously rather than consciously and may behave inappropriately. The supervisor can help the insecure therapist to identify his own unconscious approach and avoidance tendencies as they are stirred by the patient's communications. He can help the therapist define his role and his goal

¹ This point is emphasized by preliminary data from research being conducted by Drs. M. M. Gill, R. Newman, F. C. Redlich, and M. Sommers of the Department of Psychiatry at Yale University. The research compares reports of psychiatry trainees to their supervisor with sound recordings of their interviews. The comparison seems to show that the trainees' reports as to the content and dynamics of their interviews are inaccurate and at times contain significant distortions.

and thus release effective action on his part. The case cannot move forward unless the therapist can understand what is blocking it.

At first thought it might seem that the research worker who has to use a case where an inexperienced therapist is being taught would be at an unmitigated disadvantage. But there is a scientific compensation in such a case: The supervisor has to be much clearer about theory with the novice than with an experienced therapist. He has to try to tell the inexperienced therapist exactly what the theory is and even roughly suggest phrasing of his interventions. This forces upon the supervisor a clarity in regard to theory and an exactness in instruction that he would not need with a better informed therapist. For this reason the report and analysis of what was said at the therapy and supervisory sessions on Mrs. B.'s case may be a theoretical contribution.

THERAPIST DID WELL

Mrs. B.'s therapist performed very well. It is not easy to accept rigorous supervision. Required especially is control of one's own egotism. An apprentice therapist who cannot accept such supervision should be eliminated from a responsible program for psychotherapy. No apprentice surgeon would be tolerated who was too vain to learn by the instruction and example of others. The learner should be able to accept corrections and integrate them into a positive plan of action of his own. It is a definite test of personal maturity to be able to act the role of a good apprentice. If the apprentice is too dependent, the supervisor tends to feel that unfair burdens are being imposed upon him; if the apprentice is too independent, the supervisor will find it difficult to teach him. Mrs. B.'s therapist, a man of spirit and talent, did succeed in accepting supervision and yet carrying on an independent and responsible relationship with his patient.

WHAT THE SUPERVISOR DOES

In the supervisor's comments which are reproduced in the next three chapters, the reader will notice that the excellences of the therapist's behavior are not given the same attention as the defects. This has to be the case. The supervisor tries to tell the apprentice what he most needs to know, what will help his technique most. The supervisor tries to fill the apprentice's mind with the most likely hypotheses and thus to prepare him for any eventuality in the case. The supervisor is sometimes

wrong, as will be seen from the case material. Though he has greater experience, he does not have the gift of prophecy. His comments are necessarily based on the content of the case up to the point of comment.

Naturally we do not approve of every statement made by this therapist in conducting the treatment. For example, the therapist once incautiously encouraged Mrs. B. to aggress against her mother. He did this before he understood the falsity of her "baby-theft" theory. In this case, the therapist made the mistake of adopting the patient's story, not maintaining a proper reserve until the facts were clear. Hardly needing encouragement, Mrs. B. used this permissiveness to "tell her mother off." It is understood, of course, that we wanted to help Mrs. B. reach her goal of building a better relationship with her children. We did not believe, however, that immediate aggression against the grandmother would help.

RELATION BETWEEN SUPERVISOR AND THERAPIST

Supervision cannot flourish unless there is an honest and positive relationship between supervisor and therapist. From the therapist's standpoint, good supervision involves more than the teaching of technical devices. It is sometimes a general emotional education. The therapist, of course, should have a mature human-relations philosophy. But if his philosophy is defective at points, it must be supplemented by appropriate teaching from the supervisor. Usually student therapists do not have such a mature philosophy. Neither our medical nor our graduate schools give much help on this score.

For example, a student apprentice, even though married, is unlikely to understand emotional aspects of the marriage relationship in later life. He may not grasp the fact that fear plays a role in a relationship between spouses, a role which is often dismissed as boredom. The apprentice should, therefore, be galvanized with the most useful thoughts, such as the Freudian dictum that only the strongest characters can behave well in the marriage relationship. The approach-avoidance conflict in marriage which is the basis of the "spouse phobia" must be explained with homely examples.²

The good supervisor should therefore have and communicate a general philosophy of human relations. His therapeutic recommendations cannot be effective unless he has such a philosophy himself and unless it is

² The "spouse phobia" will be discussed in detail in Chapter 9.

workable. Younger therapists may not have had either the time or practice to acquire such a frame of reference. If the young therapist has been fortunate enough to acquire a mature and independent personality in the course of his own socialization he will, of course, be greatly advantaged in learning psychotherapy.³ Many of the first psychotherapists must have been talented in this way. If, on the other hand, the young therapist has had the benefit of searching psychotherapy himself he will already have come by some of the elements of a mature personal philosophy. Even in such a case, however, the living through of major life dilemmas adds something to a general philosophy which psychotherapy itself can never contribute. Living through life dilemmas teaches what really can and cannot be done, what can and cannot be borne, and gives reality to relations at first perceived only in theory. Experience gives further generality to facts learned in only one, and one's own, case.

Mrs. B.'s therapist had not had intensive personal psychoanalytic training, but he had had a good deal of clinical experience. He had been in the general practice of psychotherapy. His therapeutic technique was a mixture of too daring and literal applications of Freudian theory, advice, consolation, and other odds and ends of theory and technique gathered from the four corners of the field. However, he seemed a mature and responsible person and he seemed to have a definite knack for psychotherapeutic work. Nevertheless he made, as the reader will see, at least one quite serious mistake, thanks to his lack of better psychoanalytic training. The therapist did not really understand the Oedipus relationship. He joined the patient in taking far too literal an attitude toward it. The supervisor must, of course, share in the responsibility for this failure. He had failed to teach the relevant facts and theory clearly. When he did clarify them, the therapist was able to grasp the theory and act intelligently in the light of it.

³ The importance of personal maturity in a therapist has been emphasized by Mowrer (1951, p. 275).

THE CASE OF MRS. B.: The Patient's Defensive Story

We now introduce Mrs. B., a forty-year-old married woman with two children, a boy of twelve (Paul) and a girl of fourteen (Doris). The boy was away at a preparatory school, but the girl was attending a school near home. Mrs. B. came to a New York psychiatrist seeking treatment because she felt so miserable and depressed. "For the past two weeks," she told the psychiatrist, "I have felt quite beside myself, as though the world were coming to an end for me." She reported having crying spells and, in general, being extremely depressed. The psychiatrist described Mrs. B. as an attractive woman. Mrs. B. is married to a lawyer, a man a little older than herself.

The psychiatrist noted that Mrs. B. felt no close relationship to her daughter or to her son. She expressed a great deal of resentment at her mother about this, feeling that her mother had taken her children away from her. She said, "I just hate my mother." The patient's father died when she was about ten years old. She described him as a kind, gentle man, quite the opposite of her domineering mother. Mrs. B. married at the age of twenty-four, but at that time she felt that she could not leave her mother, and so she and her husband lived in her mother's house. Her mother took over the children's upbringing, according to the patient, until now the patient had no influence over them.

The psychiatrist could not accept Mrs. B. for treatment,¹ and so he

¹ Notice that Mrs. B. is a good candidate for psychotherapy, as judged by the eight rules set forth in Dollard and Miller's chapter, "Selecting Patients Who Can Learn" (Dollard and Miller, 1950, pp. 233-239). Mrs. B. had been given a complete physical examination and no physical disease was found.

referred her to a less experienced New York colleague who requested supervision from Dr. Dollard. The case could be closely watched because the interviews were sound-recorded and the reels brought regularly to New Haven for study.

The first six interviews form a convenient unit; in these hours Mrs. B. mainly persisted in blaming her neurosis on her mother. These first six interviews are included in this chapter. Interviews seven through twelve form another unit, since in those hours Mrs. B. seemed to put most of the blame on her husband. They form Chapter 5. The closing hours of the case (interviews thirteen through seventeen), in which the patient comes to grips with fundamental life problems, form the sixth chapter.

In the chapters covering "The Case of Mrs. B." the pages of the text are divided by a horizontal line. Above this line is the material of the case résumé. Below the line are the supervisor's comments, instructions, and orienting thoughts as addressed to the therapist in the control session at which the sound-recorded interview was played back. These discussions were taken down in shorthand so that complete material on this case would be available. We have presented both résumé and supervisory comments in order that the reader may first participate in the therapeutic hour itself and then immediately in the supervisory session which followed it.

The reader will notice that letters "A," "B," "C," etc., have been inserted into the case material. These letters refer to the supervisor's comments concerning material immediately preceding the letter. The comments of the supervisor were designed to correct technique and to prepare the apprentice for the next and eventual turns of affairs in the case. A kind of prediction often is involved, sometimes of a specific kind; at other times the supervisor will know that there is "something missing" when he does not know exactly what it is. The supervisor's comments as they occur in the text are based on the material available up to that point. There has been no attempt to restructure his opinions to make him seem more prescient.

Some of these quotations from the supervisor and therapist will inevitably arouse critical responses in the informed reader. Almost any therapist or supervisor would have done this and that differently. We expect to find most helpful the views of those commentators who have themselves published their own uncensored remarks as therapists or supervisors. Rereading the awkward things said, re-evaluating the plain

cues missed, often produces humiliation in us. Occasionally, we must confess, we found ourselves doing better than could have been expected.

It was not at first intended to make this a "research" case. The original motivation was entirely therapeutic. The fact that we could see rather clearly what happened in the therapy—and why—led us to feel, after the case was closed, that publication might be instructive.

FIRST INTERVIEW

The therapist had been instructed to use the first hour of the treatment to explore the main facts of the patient's life, to find out something of her childhood, to discover the problems that troubled her most, and to try to estimate how much anxiety she could bear. At the start of the hour the therapist took up the practical matter of arranging the appointments. He said that he could see the patient for two hours a week—an hour each on Monday and Friday. Mrs. B. said, "I think Monday is better for me."

The therapist pointed out that he wanted to see the patient twice a week, since it would be possible for him to see her only over a ten-week period because of other personal commitments. The patient said, "You mean that will cost me more money each week?" She continued, "You see, I'm doing this on my own. I was stealing money from my house-keeping money, and I figured that if I could steal ten dollars a week it wouldn't be bad. I don't know whether I could steal twenty dollars a week." (A)

Comments at Supervisory Session

(A) *Need to strengthen patient's motivation.* The supervisor pointed out that this matter was central in the treatment and if not dealt with would block any progress. He said, "It is not just a matter of money. This is tied in with her whole pattern of personal relations. It is related in a very fundamental way to her character."

Then the supervisor advised that the therapist must arouse the patient's motivation. "You should say to her something like this: 'After all, you have been depressed, so it seems to me that it would be quite worth your while to make a good deal of a struggle to work out this matter with your husband. You are forty years old, and if

The therapist asked whether she had thought that a longer period of time would be available to her. She replied, "I didn't know how long it would take. I don't know whether my problems are such that it would take very long at all. I haven't said anything to anyone about this—not even my husband. And I felt that I didn't want to come to him for the money. That's why I thought I could steal it out of my housekeeping money every week. Twenty dollars seems like a lot." (B)

The therapist emphasized that if at all possible he would like to see the patient twice a week.

The therapist then took up the matter of the psychological tests that he wanted to have given to her for diagnostic and research purposes. Mrs. B. inquired what kind of tests they were, and the therapist tried to

the life insurance tables are right, you are going to live over thirty-three years more, and that's a long, long time. You have to live every day of it, day by day. If you are depressed all the rest of your life it can be hell.'

"I think the points to keep in mind," the supervisor said, "are these: first, she must be aware of her neurotic disorder and how it handicaps her; second, she must have some hope that psychotherapy will help her to get rid of the disorder; and third, she must make the resolve to accept the conditions of the treatment."

(B) *Patient must tell husband she is in treatment.* The patient is making the therapist an immoral proposal: that she steal money for the therapy and that the relationship be kept a secret from her husband. The young therapist is thus swiftly exposed to neurotic wiles. This incident illustrates the practical importance of insisting on an honest and straightforward relationship. The supervisor insisted: "There is a grave danger to the relationship between the patient and the therapist if the husband is not told of the treatment. If he is not told, then the patient can say at any time, 'I can't come; my husband won't let me.' The patient can also reproach the therapist at any time for having collaborated in a dishonest action. Why should she tell the truth if he doesn't? People who are critically involved with the patient sociologically, as the husband is, must know about the treatment. They need not know what takes place in the treatment, but they must know it is occurring."

explain that they were not intelligence tests or physical tests but were personality tests intended to be helpful in diagnosis.

The therapist then announced that sound recordings would be made of the interviews to save him the trouble of taking notes and that these records would be protected like all doctors' records. The patient readily accepted the recording. Then the therapist announced, "The rest of this hour we want to spend in your giving me a brief résumé of your life."

The patient began, "I can't remember very much back—only that I was a very nervous child." She described early fears and her mother's lack of sympathy with her when she got frightened. She recalled that her father had died when she was only ten years old: "It was just ter-

"Old sins and lies that do not affect the structure of the psychotherapeutic relationship can sometimes be ignored by saying, 'That's what you had to do in the past. There's no question of blame, but you should find out why you had to do these things.' But where, as in this instance, a lie can be used to destroy the therapeutic situation, the therapist must draw the line."

This incident brings out the further point that it is not only for idealistic reasons that the therapist insists on honesty in psychotherapy interviews. There is a psychological reason for truthfulness: in order to behave adaptively one has to have a correct description of reality. That is why the therapist must insist on the truth. The patient is likely to believe his own tales if the therapist consents to them. The supervisor, therefore, suggested to the therapist: "You should say to her, 'It would be impossible to maintain a masquerade for any length of time, since you are married. It will be impossible to conduct the treatments unless your husband consents to them. For me to see you in secret is impracticable. But there is still another reason why I couldn't see you under those conditions. In order to go on successfully, everybody has to be telling the truth. The basis of this treatment must be honesty and frankness.' When you have defined the situation in this way, you will have performed your first important act as a therapist. If the patient then decides not to come under these conditions you will have saved her and yourself some time."

rible. I couldn't understand how a man could go to a hospital on a Friday and die on a Wednesday."

"After my father died I lost all interest in school; no one was really interested in whether I did well or didn't do well," she said in an accusatory tone of voice. She reported that her mother had worked after her father died and that she herself had had a lot of chores around home. Her mother had been very strict with her, although good to her in the matter of buying her clothes and other things.

Then when the patient was about twenty, she met her husband and started to go out with him. They were married four years later, but they lived in her mother's house.

Mrs. B. had her first child two years after her marriage. She said, "And I was miserable. My mother took complete charge. That's one of the reasons why I came in to see you. I really felt as though my daughter really never belonged to me. She would never come to me for anything; she would run to my mother. And it was about the same with Paul too. Even now when he comes home from the school for vacations he always hangs around his grandmother."

The relationship between Mrs. B. and her mother had never been one of warmth and affection. "She always hit us," said Mrs. B., "She never reasoned with us about things."

The children had not been planned, and Mrs. B. said she had not known how she and her husband, with children to take care of, would manage financially.

The therapist asked, "Now would you tell me something about your relationship to your husband?"

Mrs. B. replied, "Well, Bob is awfully nice, sweet, has a wonderful disposition. He's really a wonderful man. He gets very angry at my mother because, I think, she has Doris and Paul under her power, because she buys their clothes and other things, and my husband is hurt because he feels that she shouldn't do that. I guess it makes him feel he isn't successful. He feels very badly about it. Now we haven't got too much to say with either of the children." (C)

(C) *Therapist should challenge the implausible.* Commenting on this the supervisor said, "It's hard to see how the grandmother could have had such an influence over the children unless the mother

When the therapist made a routine inquiry about the patient's sexual experience she answered, "I remember my mother telling me, if any boy kissed you, you were going to have a baby." She said that when she started going out with boys she was frightened. She wouldn't let anyone come near her because she was afraid she would have a baby. She asserted, "Sex never meant anything to me because I was always living in my mother's house. I was afraid; I was afraid to have my husband come near me for fear my mother would walk in, or something. So we could only have intercourse when we went away on vacations." (Mrs. B. was no longer living with her mother at the time of the treatment, but her mother visited her quite frequently.)

Mrs. B. asserted that her sex life at this time was satisfactory. She reported that when they moved out of the mother's house, "We were very happy." And their sex life was better.

At the end of this hour the therapist said, "It's important that this secret, not telling your husband about your coming here, should not exist between you and your husband. A secret of this kind would be a considerable burden."

Mrs. B. said she didn't want to tell him because she was afraid. The therapist questioned why. Mrs. B. replied, "Well, I don't know what he will think if he knows I'm seeing a psychiatrist."

The therapist insisted that it was important to clear this up. "The secret is unwholesome in the whole relationship. It might come in the way of the treatment."

Mrs. B. said, "Later I might have the courage to tell him, but right now I don't feel as though I want to. I'd rather do it like I'm doing. I don't know what he'll say."

neglected them or was hostile to them." Implausible details must be questioned. False assumptions of the patient and the incorrect account that the patient gives must be challenged.

The supervisor advised the therapist, "I think you should refuse to understand how the grandmother could take a child away from a mother. If the therapist does not challenge this belief the treatment cannot move forward. Naturally, don't call the patient a liar. Just be stupid; fail to understand how such a child-stealing could occur as described."

The therapist again insisted, "Your husband should know. This is really one of the conditions for our working together."

The patient asked, "Supposing he tells me he doesn't want me to go, what will I do? I still want to come; I want to get straightened out. Suppose he says no?"

The therapist concluded the hour saying, "This should be the first part of your work in the treatment. I would be surprised if your husband took a very negative stand."

The therapist told Mrs. B. that she would have to tell her husband within the next week or the treatment could not continue. After all, he reasoned, the husband already knew that his wife had been advised by her medical doctor to seek psychotherapy; why should he fail to consent?

SECOND INTERVIEW

The therapist had been instructed to use the second hour to explain what the treatment would be like, to announce the rule of free association, to reduce any fears about the treatment, and to clear away any false notions that the patient might have.² The therapist found that he did not need a full hour to make these explanations, and so after giving these instructions and explanations he launched into the main part of the treatment.

Before giving the information and explanation that was to be included in the second hour, the therapist asked the patient how she had gotten along with her "homework," i.e., with the task of telling her husband about the treatment. (A) Mrs. B. replied, "Well, I told him about it."

Comments at Supervisory Session

(A) *Let the patient set the theme of the hour.* The supervisor instructed the therapist: "Don't start the interview—even on an important issue like this. She should have had a chance to begin it for herself. Your question may be less valuable than what she would bring up for herself. A patient comes in with something on his mind. Give him the chance to get out the theme for that day."

² The general public is poorly informed about mental disorders and psychiatric techniques. This fact has been documented by Redlich (1950) who reported a survey of public knowledge about psychiatry.

He was greatly surprised. He wanted to know where I was getting the money from." Her husband had agreed that he would be willing to pay for one hour of treatment a week if she could get the other ten dollars from her grocery money. (B)

The therapist announced that he would do most of the talking in this hour because he needed to tell the patient what lay ahead. Mrs. B. interrupted him to ask, "Is this being recorded now?"

The therapist answered, "Yes, I told you the last time that our interviews would be recorded." Then Mrs. B. inquired whether the psychological tests had been recorded, too. The therapist said they had.

"Oh, I gave some stupid answers!" Mrs. B. exclaimed. "I was petrified about the tests. I've had butterflies in my stomach ever since, worrying about it." (C) The therapist commented that he had tried to explain

(B) *Setting the fee is part of the treatment.* On the matter of whether Mrs. B. could really afford twenty dollars a week for treatment and how she would pay for it, the supervisor pointed out, "The money question is really involved in the therapy. Perhaps she is lying about her husband's income as a lawyer. Perhaps she is lying about his reaction to her request for the money. It's not like a lawyer to tell his wife she would have to take money for treatment from the household budget. Also her husband's income is probably pretty good. She told the psychiatrist who first interviewed her that she could afford only ten dollars a week, but maybe that's not true. In any case, as Freud said (1924, Vol. II, pp. 351-352), the money and the setting of the fee should be considered as part of the treatment.³ In this as in the other aspects of the treatment, honesty and realism must be the rule.

"In analytic therapy the rule is that the analyst never changes the fee. He may allow delay of payment, but he doesn't reduce the fee, nor does he increase it. I don't think this rule is entirely sensible, because if a person's financial circumstances should change I don't see why in a dire case the fee should not be reduced—or increased, for that matter; the therapist should feel he's getting a fair deal if he is to do a good job."

(C) *Therapist could reassure patient about tests.* Commenting on the patient's expression of concern about how well she did on the

³ Cf. also the discussion of "Financial Arrangements for Analysis" in Kubie (1950, pp. 135-143).

the kind of tests that were given to her and the reason for them. She admitted that he had done this but said she had nevertheless dreaded the tests.

The therapist then explained that the treatment was not physical but instead involved talking. He stressed the difference between physical and mental disorders. He reassured Mrs. B. that her trouble was not the same as "insanity," but a much less serious disorder. He stated that he would not give shock treatments or any kind of surgery but would stick to talking.

Then he reminded the patient that she felt depressed. "We want to help you to live a happy, comfortable life rather than being bothered by depression," he continued. He explained the rule of free association. "You are to say whatever comes into your mind just as soon as you think of it . . . without first trying to think about it and wondering whether it's really important. It doesn't have to be logical; it doesn't have to make sense. There will be things that may be embarrassing to say—things that one doesn't ordinarily talk about. But those things too you should tell me."

The therapist misunderstood the supervisor's instructions, and instead of beginning the free association immediately he said, "Now we don't want to start working on this today because we want to start in and have a full hour."

Mrs. B.'s response to these instructions was to say, "You're a total stranger to me. It seems strange for me to come out with some of the things that I think about. . . . I didn't know that anything I had in my mind I could come out with. I thought they were just the most important things you wanted to hear."

psychological tests, the supervisor said, "In her case, I don't see any harm in saying, 'You did well on the tests.' The tests can't really be interpreted to her. We can't give her a course in clinical psychology, so to speak. Behind her question is the idea, 'This means I'm going crazy' or the idea, 'This is a test of my adequacy.' A test may be a symbol of punishment for her. If she asks about the tests again, I think you could say, 'The doctor who gave the tests told me that you did well.' If this fear of examination is a fundamental unconscious reaction, it will come up in some other connection."

The therapist insisted that the rule of free association meant that she was indeed to say whatever occurred to her. Then he said, "I wonder whether you'd tell me a little bit more than you did last week about your daughter?" (Suggesting topics was contrary to the supervisor's advice; the therapist should have begun the free association.)

Mrs. B. said, "Doris is a perfectly normal little girl in all ways. She has been quite well. She has a wonderful time like kids do. She plays the violin very well. . . . I can't say anything against her at all. . . . My mother practically brought her up. My mother spoiled her. I mean she picked her up every time she cried, which I didn't like." Then the patient listed all the children's diseases that Doris had when she was little. She continued, "And lots of times when we argue about things she'll tell me she hates me. She does come right out and say, 'I hate you. I think you're mean,' when she can't get her own way. . . . I think that this is the age that they should really be close to their mothers and ask them things. . . . I always give in so much with her that she just takes what comes."

Mrs. B. went on to express a good deal of resentment toward her mother and said, "I have to get this resentment straightened out. I don't know how to talk with my mother without making a fight out of it and saying a lot of awful things. . . . I'm more concerned about this than anything else."

The therapist responded, "I won't ever be in a position to give advice to you. We can try to work out things together. Besides, we shouldn't try to single out any one thing, because a mental difficulty such as yours hangs together. It's not a good idea to pick out one thing and try to work on it." (D)

Mrs. B. insisted that her mother was really her main problem: "And

(D) *Therapy cannot be slanted toward just one problem.* The supervisor pointed out that the therapist did not yet know enough about the patient to slant the therapy toward solving just one thing, such as her conflict with her mother. He advised, "The best thing is to focus on the rule that she should talk about whatever comes to mind." He added that the patient's hostile feelings may be so strong that she wants to kill her mother. The real problem is not *that* she hates her mother but *why*.

I'd love to get it straightened out. I mean if we could do it within the next couple of weeks maybe we can straighten it out." (E)

Mrs. B. continued: "It's a terrible feeling to—to realize things that you—I mean that it must have been going on inside of me for a long time." She cleared her throat. "And I didn't realize until I heard some other mothers talking about their girls how far away Doris is from me. And I've certainly been a good mother to her. The other day it was raining, and I called for her at school. And then she came home, and she met a girl and they went out bicycling. And she came home, and she was soaking wet. So there you are! I mean you do the best you can—you can't do anything else, that's all."

The therapist asked why Mrs. B. couldn't talk to her mother about Doris. He wondered how Mrs. B.'s fear of talking to her mother originated. Mrs. B. said that she could never talk to her mother, even as a little girl. "I don't know whether it was because she didn't have the time, or whether she didn't understand, or what it was. I don't remember ever talking to my mother about anything. I don't think my sisters ever did. I guess she was too busy."

The therapist intervened, "But at that time you were a little girl. Now that you're an adult, it's different. Now you can talk to your mother on equal terms." (F)

(E) *Refuse to understand the improbable.* The supervisor reiterated his advice to the therapist that he should refuse to understand how a grandmother could take a child away from a mother. A therapist must refuse to understand the improbable. This is the opposite of accepting everything the patient might say. By accepting the patient's view of the matter one would not make any progress, but, as is shown quite well in this case, when the therapist refuses to understand the improbable the therapy moves forward.

(F) *Teaching the patient to discriminate past from present.* The supervisor commended the therapist for the way he tried to teach the patient to discriminate between the past, when the patient was a little girl and could not be assertive and independent, and the present, when she can. In this instance, the therapist was teaching a discrimination by labeling the differences between past and present. His object in doing this was to reduce the generalization of fear. He

Mrs. B. felt that she could never learn to talk to her mother: "I don't think I'd be able to express myself to her in a sensible way where she would listen to me. I think the only way I could do it is by fighting." Mrs. B. asserted that she'd rather keep peace and not fight or argue, because she was a peace-loving person.

Mrs. B., encouraged by the therapist, reminisced about her childhood. She described her father as sweet and good-natured, her mother as ill-tempered and mean. Then, discussing her relationship with Doris, she complained that they were not as close as they should be. She ended the hour on this theme.

THIRD INTERVIEW

The patient started the hour by saying, "I feel so miserable I wanted to cancel the appointment."

The therapist observed that with this hour the patient would start free association. Mrs. B. replied, "I don't feel like talking." Then she remembered that a few weeks hence the therapy appointment would come at the time of a rehearsal for a play that her dramatic group was putting on. The therapist told her that since this was some time distant they would discuss the conflict of dates later, but that it probably would not be possible for him to change the time of her appointment. (A)

was showing the patient that, while it was appropriate for her to be afraid of her mother when she was a child, it is inappropriate for her to carry over this same fear to adulthood, when her mother no longer has power over her and cannot punish her for appropriate self-assertion.

(A) *Therapist should remind patient of her misery.* The supervisor commented on the matter of the patient's attending rehearsal for the play she was supposed to help with: "I suppose she either has to break her word to the director of the play or to you, but after all she has been depressed. You could say, 'You have just a little time here. You have to decide how to make use of it. I think you are in sufficient trouble so that you should seriously consider keeping your appointments here.' You must motivate her to come and remind her of the misery that she is bearing.

"Freud said that he used to remit fees when patients would not

Mrs. B. then announced, "I get terribly panicky when Doris gets sick. I don't seem to worry about Paul that way—but then he's off at prep school and in the summer he's at camp. Yet Paul used to have asthma attacks sometimes when he was younger. I used to worry about him then, I guess. What makes me so panicky when my *daughter* gets sick? Is it because I have a guilty feeling? Is it because I am afraid my mother will be furious if I didn't do the right thing about my daughter? I'm terribly nervous when she gets sick. I get panicky. I'm not concerned about myself. I think she is going to get very sick and die." (B)

come, but finally he charged them for every session, and he found that people almost never missed the session under those conditions (Freud, 1925, Vol. III, p. 346). He used the fee as a counterforce to oppose the resistance. Certainly one should not charge for every hour without introducing the idea that missing an hour often indicates avoidance, that it is not accidental; that missing may be a way of avoiding telling something important; and that the reason for charging for each hour is partly to put an additional force on the side of coming and an additional punishment on the side of not coming. However, our main reliance has to be on the misery that motivates the patient's coming for treatment, and I think that you should remind this patient of her misery and of the hope that psychotherapy can help her become less miserable."

(B) *Mrs. B.'s oversolicitousness conceals hostility.* The supervisor pointed out that the patient's panic about her daughter's sickness illustrates a reaction formation. The therapist could deal with the question by saying, "The fear that your daughter will get sick and die is, of course, unreasonable; she is, as you have said, a healthy child. But there is still a problem. Why do you fear for her without good reason? There must be something else going on."

Such a reaction formation as that just described could be reinforced in this way: The patient has competitive feelings toward her daughter. Her daughter is now becoming a young woman, acquiring the sexual characteristics of an adult. The daughter's growing up increases the rivalry between daughter and patient, and the rivalry in turn increases the patient's hatred of her daughter. Expression of this hatred, however, would produce tremendous anxiety because

Her next thought was, "Did I pass in the examination?" (that is, the projective test).

The therapist replied, "It has nothing to do with your intelligence, it's a diagnostic test, but you did all right. Why are you so concerned about it?" Mrs. B. indicated that she had always been concerned about tests.

Then she said, "When we were younger, we never had a chance to express our opinions to my mother, so I guess it will take a long time to learn to talk to her like a human being." A fairly long pause followed, then the patient said, "What makes me so panicky when my daughter gets sick?" (C)

The therapist inquired, "What did you think about during the pause, when you were silent?"

expression of hatred has formerly been punished and because expressing such hatred toward one's child violates all our moral teachings.

But a closely related sentence, "If my daughter got sick she might die," does not arouse the same anxiety as the sentence, "I wish my daughter would die." No one is culpable in case of death from illness. And so the former sentence can occur without the same degree of anxiety and yet can be reinforced by gratification of vengeful wishes against the daughter—the same gratification that would reinforce the sentence, "I wish she would die." This is an example of resolution of conflict by reaction formation, wherein oversolicitousness conceals, yet calls attention to, a wish for the daughter's death.

(C) *Therapist should point up patient's conflict.* When the patient asked, "Why am I this way? Why am I so concerned about Doris?" the therapist, rather than trying to answer the question, should tell the patient that he doesn't really understand what her relationship was either to her mother or to her daughter. The supervisor advised, "You could point out that there is an unanswered question and say, 'I don't see how your mother could take your daughter away from you.' That leaves the question, 'Did you reject your daughter?'"

"She wants the therapist to accept her story about the whole thing and not to make any demands upon her. The rule is to try to get her to see how she is distorting her view and thereby escaping the pres-

"I was thinking, 'I have to say what I'm thinking,'" Mrs. B. replied.

"Then you should say that," the therapist reminded her. "Say whatever occurs to you."

"Why am I so nervous when my daughter gets sick? I'm always thinking she's going to get sick and die," Mrs. B. asked. The patient then asked several personal questions of the therapist, which he did not answer.

The therapist said, "After all you are the one who is in treatment. The problem is for you to tell me what you think." (D)

Mrs. B. said, "I don't know what to say, I'm just rambling on, not making any sense." (E) "We were planning to go up to Eastwood this weekend to see Paul. It's Parents' Day and he wants us to come. Paul is

sure of her own conscience, which is strong enough to produce guilt. She has been seething in conflict. I think when you get the chance to point up the conflict you should do just that."

(D) *Personal questions are a way of escaping the hard work of the treatment.* The supervisor commented, "In such a case, I would remind her why she is here. She had a depression. Say something like, 'You have had some symptoms that made you very miserable. That's why you are here. If it weren't for that, we would not take this time to spend on you. You have agreed to do something about your problem. This is the place where you have a chance to demonstrate that.' In other words, when the patient asks personal questions of the therapist, the therapist must remind the patient of her motivation for being in the treatment and must point out how raising this question permits the patient to escape from the hard work and the anxiety of dealing with her own problem."

"I think in general you could say that there is no reason for bringing the therapist's personal life into it, because it just wastes the patient's time. One can say, 'If you want to know personal things about me, after we finish you can easily find them out.' Another way of answering is, 'Why does this interest you? I don't want to be rude to you, and I don't have any reason to conceal anything about myself, but it has been found that the time is wasted if the therapist talks about himself. However, I have a question for you: Why does this concern you? It looks as if maybe there is something important that

there on a scholarship, you know, and I imagine he feels a little strange among those boys who have more money—not that he has exactly said it in his letters, but it is hard on a boy being pointed out as being on a scholarship, I guess.” She talked about various trivial matters, then said, “Can you answer one question for me?”

The therapist nodded. (F) Mrs. B. continued, “Is this the same routine as psychoanalysis?” The therapist inquired why she asked. The patient replied, “A friend of my sister’s is being psychoanalyzed, that’s why I asked.” (G)

you have to talk about and you’re trying to avoid it, by asking me about these things.”⁴

(E) *Attempt to follow the rule produces fear.* Noting the patient’s statement that saying whatever comes to mind is ridiculous, the supervisor suggested, “I think you can say, ‘Maybe you have something on your mind that you are afraid to say.’ Ridiculing the rule is an escape from fear, from the fear that was produced when she attempted to follow it. Her statement, ‘It is silly to say whatever comes to mind,’ was reinforced by escape from this fear.”

Likewise, her personal questions, inquiring about the therapist’s personal life, his professional acquaintances, and so on, are reinforced by escape from fear. If the therapist can be got to do the talking, the patient will not have to talk about the topics that arouse fear in her.

(F) *Therapist may not want to answer every question.* As another resistance against continuing to talk about matters of painful concern to her, the patient asked a question about technique. The supervisor recommended that the therapist should have said, “Let’s hear it,” without nodding and thus committing himself to answer the question. The therapist may not want to answer all the questions of the patient.

(G) *Therapist should not spend time discussing theory.* The supervisor advised, “In this case I would ask, ‘Why do you want to know that?’ You can’t go into comparing this treatment with psycho-

⁴ The questions might also mean that the patient’s feelings about the therapist have been aroused and that these unconscious feelings excite the questions. This might have been true in this instance, but was not discussed with the therapist.

The patient then reminisced about her father's death. When she was about ten, they got her out of bed to take her to the hospital to see him because he was dying. The therapist pointed out, "That may be a reason why you are so afraid to go to the hospital." (H)

FOURTH INTERVIEW

Mrs. B. announced at the start of the hour, "I've been thinking so much in the past two days that it's been terrible. I think I'm more depressed than before I saw you. (A) I feel as though I was absolutely hopeless. I can't do anything. I don't know how to do anything. I have no ambition. I don't care whether I finish anything. I can remember my

analysis. She is bothered by the fact that she is going to have to face some painful facts if she talks, but so long as she can keep you talking she is winning a battle. If you go too far in reasonableness, you'll be so reasonable you can't help her! Every time you give her an unnecessary explanation you're doing something against her interest."

(H) *Discrimination between past and present.* The fear of the hospital constituted a real problem in this woman's life, and so it was quite appropriate that the therapist should deal with it and should try to discriminate for her between the reality of the hospital as a place where she goes now when she gets sick and the notion that she had about hospitals as a child. She may have felt, "That's how you die. You go to a hospital," or "That was how I lost my daddy's love. He went to the hospital and I went to see him there and that's how I lost him." Such a discrimination should weaken fear by prompting a rational analysis of the hospital. The old fear is weakened by realizing that many sick people of today go to the hospital and get well, etc.

However, the therapist's activity is still on a superficial level. The patient may also love and fear to lose the therapist, like her father; or resent him and fear that her hostile wish will come true.

(A) *Patient is blaming therapist.* The supervisor noted that the patient blames the therapist for the way she feels. She seems to feel worse, and she tries to lay the responsibility for it upon the therapist. The supervisor said, "This is childish. A child might see no way out

mother telling me I can't do anything. I can't make a bed. I can't sew. I can't cook. . . . I might as well be dead as go on like this!"

The therapist replied reassuringly, "That is why you have come to treatment."

"All of a sudden," Mrs. B. continued, "I've—I've never thought about myself as much as in the last few days. I feel I'm useless in this world. But I feel guilty because I'm blaming my mother for all this. I didn't realize she was the cause of all this. I didn't know what was causing it, but now I feel this has always been my trouble." The patient was weeping as she said, "What's the use of going on living if you feel like this?"

Then she said, "You have to help me. I can't go on this way. I'm afraid to open up my mouth; I'm afraid I'll say the wrong thing."

The therapist inquired, "What are you afraid of?" (B)

of a problem and feel that other people must be to blame. This is her typical personality maneuver—aggression toward others whom she blames for frustration. This is, of course, a transference response—i.e., it is generalized from an earlier situation in which it was learned, despite the fact that your behavior offers no justifiable reason for blame."

(B) *Therapist should challenge patient's projections.* The supervisor told the therapist, "You don't sound very sympathetic there. It would be better to say, 'If I could snap my fingers and make you well I would do it, but unfortunately I can't.'"

"At the same time that you are really sympathetic, you should reject the placing of the entire responsibility on you, as she does. Blaming you is a projection. She is putting the burden on you to an unfair degree. She is trying to manage you a bit by asking you questions, by demanding that you solve her problems because, after all, it is you who 'made her worse.'⁵ I would challenge this because she has discussed these problems many times with her sisters and her friends, of course. She has thought about these things before. She is

⁵ A general discussion of projection is found in Dollard and Miller (1950, pp. 181-184). Whiting and Child (1953, Chapter 12) also discuss projection, and they present evidence that fear of ghosts, spirits, and sorcerers is stronger in societies which punish children's aggression severely. Whiting and Child show that this finding is consistent with a conflict theory interpretation of projection.

Mrs. B. replied, "I don't know. . . . Is it that I'm afraid of my mother? I feel guilty talking behind her back. . . . It all came to me yesterday. I never thought about it before."

Then Mrs. B. repeated her cover story, complaining that her mother had interfered with raising her children. "I've told you how she has always been about Doris. She was the first one. But then, too, my mother was always lugging Paul around when he was a baby and showing him off to her friends. She would keep saying, 'Haven't *we* got a fine boy?' and things like that. And all those women kept picking him up and hugging him—I used to be furious because I knew they were likely to give him colds and Heaven knows what kinds of infections. Of course we moved away before Paul got to running around and talking, so my mother hasn't seen as much of him as she did Doris." She emphasized that her mother "bosses us all around."

saying that you've made her worse by making her think of things that she hasn't thought of before. That's only partly true."

In the same way that she is blaming the therapist for making her worse, the patient lays the blame for her neurosis on her mother. On this point, the therapist might say, "I don't believe this problem is just with your mother. The real problem may lie somewhere else in your life."

The therapist could point out to her that she is blaming him now: "It seems to me that you are really saying the same things about me that you say about your mother, but what you say isn't true.⁶ You were depressed before you came here. You haven't been here long enough to scratch the surface. The things you are talking about here have already been talked over with others." If he doesn't resist projections, the therapist will find that the patient has recourse to this response every time she runs against anxiety-producing thoughts and will repeat that he is making her worse.

In blaming her mother, the patient is in effect giving a theory of childhood origin of this trouble, presenting herself as the victim of a domineering mother. But somehow, this does not ring true. A more adequate theory is that she was badly frustrated and foolishly

⁶ In dealing with transference, generalized responses must first be identified (Dollard and Miller, 1950, pp. 276-277).

Sounding very depressed, the patient stated, "I didn't think I was going to last until today. . . . I tried to call you at your office but no one was there last night. If I ever feel so desperate again could you give me an extra appointment? This has been on my mind and I had to get it off.

"When will I start feeling like a human being? I'm such a failure! It's so hopeless. I feel it's the end of my rope. If I'm going to feel like this, I might as well be dead. Nobody needs me for anything. My children don't need me."

"How about your husband?" the therapist asked.

She answered: "I don't know. He walked in last night and I was crying and I said, 'I'm terribly depressed,' and he said, 'Is dinner ready?' That's all! Nobody needs anybody really. Nobody cares about anybody. Nobody cares how you feel inside. (C) . . . It's awful when you find out something terrible about yourself." The patient was sobbing.

handled in early life. As a result, she believes that if you don't look out for yourself, no one else will. She cannot give love to others, yet she demands it from them. Demanding love herself, she feels ashamed that she cannot give it. Her problem is not that she was dominated by her mother; her problem is a lack of love for other people.

The supervisor summed up by noting that the patient was acting toward the therapist in exactly the same way she acts toward her mother, namely, blaming him for her difficulty, rather than accepting responsibility for her troubles and trying to do something about them herself.

(C) *Patient is unable to love anybody.* The supervisor pointed out, "She doesn't care about anybody; that's why she feels so awful. She feels herself as a frightfully bad person." One of her problems is that she can't give love to others. This statement, "Nobody cares about anybody," is also her way of reproaching the therapist.

The supervisor suggested, "Perhaps we should take up her remark that nobody cares about anybody. You could ask, 'You mean you don't think that I have any real interest in you as a person? Is it possible that you yourself feel threatened because you don't feel you can love people as much as you would like to? Since the only safety

"But I wonder why you should feel so guilty?" the therapist intervened.

"Maybe it's because I've put on an act all these years—to everybody," she answered.

The therapist made the point that the patient was no longer a little girl. "It seems unusual for an adult to let someone walk right over her. What would happen if you did answer your mother back?"

The patient replied: "I threatened her one day. I said, 'If you talk like that to me I'll never let Doris come near you.' I can't do it in a sensible way. I do it in a terrible way." (D) (Mrs. B.'s tone was very aggressive.) "I can't talk to her calmly! . . .

"Once I was at a party and I was tight and a man said, 'You don't know what you're talking about,' and I threw the glass in his face; I threw the Scotch right in his face."

"Is that the kind of thing you'd like to do to your mother?" the therapist asked.

"Throw something in her face? I think it would be the only way I could fight back with her," the patient answered defiantly. "But I can't go on feeling that I can't do anything, that I'm stupid. I've never been so unhappy in my life. . . . I have absolutely no love for my mother. I *hate* her! Why didn't I discover it before? . . . I haven't accomplished anything. In my whole married life I haven't done anything. I don't know why I go on living!"

The therapist offered the reassurance that with treatment there was

is in loving and being loved, you feel miserably exposed and insecure."

(D) *Patient may be afraid she would really hurt her mother.* The supervisor proposed that one reason for her depression may be that she feels that she can't express any reasonable opposition to her mother, for she is afraid that if the barrier to the expression of opposition were removed, she would commit one dreadful act after another. She may fear that if she opposes her mother she would also "beat her up," that the slightest rebellion would lead to a terrible aggression. "But," the supervisor counseled, "you could give her confidence that she could oppose her mother in a reasonable and proportionate way."

hope that the patient would make a good job of the thirty years or more ahead of her. (E)

Replying, Mrs. B. complained, "I haven't slept in two nights because I keep thinking all the time. . . . I feel terrible now even though I've told you."

FIFTH INTERVIEW

The patient said that in general she felt worse since starting the treatment but added that she felt better now than in the preceding hour. "I feel worse but entirely different than I did when I came here, into the treatment."

The therapist remarked, "I've had the feeling that you have blamed me, and blamed the treatment for the way you feel," and indicated that this was unreasonable. (A)

Mrs. B. reported that her husband had questioned her about what she

(E) *Therapist should note gaps in patient's account.* The supervisor called attention to the fact that the patient hasn't mentioned her husband except to say, in a very defensive way, "Bob is sweet. I can't say anything against him." The therapist might say, "We have covered your ideas about your mother pretty well, but I know this can't be the whole story because we have heard practically nothing about your husband."

The supervisor observed that Mrs. B. is acting as though her marriage did not exist. The great resentment that she shows may not really have its origin entirely in her relationship to her mother. Her talking so much about her relationship to her mother may conceal what is a more important problem—the relationship toward her husband.

"In making this interpretation," the supervisor said, "you must always assume that there is something in her that wants to be well. You should be as nice as you can to her. There must be something good in her. So, I would call attention to the fact that she hasn't mentioned her husband, though the relationship must be important."

(A) *Patient blamed the therapist.* The supervisor, commenting on the patient's saying that the treatment has made her worse, said, "She has a strong tendency to put you in the wrong, yet she can be

discussed with the therapist. "But I don't really feel I can discuss it with him. Do you think I should?" The therapist explained that he wanted her to bring out with him the things that were occurring to her rather than to discuss them outside. (B)

The patient continued, "I don't want my husband to think I'm hiding anything, but I don't want to tell him what we talk about. . . . I said, 'It has nothing to do with you at all. We talk about what happened when I was a little girl.'"

The therapist intervened, "Of course, that's not quite true. If you happened to think about your husband we would want you to talk about that." She replied that she could not talk about her husband because "He's so sweet, I can't talk about him. . . . The only thing I'm worried about is my mother."

The therapist pointed out, "But the relationship to him must be important. How can you omit it from the treatment?"

"I've never asked him for a lot of things like some wives do," Mrs. B.

got to abandon it.⁷ You must try to oppose what is unreasonable in her, but be nice to her as a total person. She started by blaming you, and when she saw you didn't accept the blame, she felt much better."

(B) *Patient should not discuss the treatment with others.* The supervisor advised, "When she asked you about discussing the treatment with her husband, you might have said, 'It is usual in these situations not to talk about the treatment with one's friends or even with relatives. When the treatments are over, then you can say whatever you want to about them.' In advising not talking about the treatment outside we follow the advice of Freud (1924, Vol. II, p. 357). This is particularly appropriate here because the patient wants to use the authority of the therapist to justify her anger against other people—against her husband, to tell him why he's to blame for her troubles—against her mother, to aggress against her, to blame her for making her the way she is.

"She should ask her husband if he doesn't mind if she doesn't discuss the content of her treatment while it is going on because the relationship is between you and her and should be kept confidential."

⁷ Cf. the discussion in Dollard and Miller (1950, p. 119) of social training in thinking, especially the section, "Making a correct report of the environment."

said. "Really, I can't say anything about him—anything that would make me feel guilty about talking about him. . . . He has a good reputation. He doesn't demand anything. . . . I can't say anything against him at all." Then she talked in a bitter tone of her daughter, "Doris wants a new evening gown for a dance, and I told her, 'I don't think we could afford to buy it right now.' (C) And she told me, 'If you don't buy it I'll go to Granny and she'll buy it for me!' I keep getting that 'if you won't do it, Granny will.' It's a stab!

"Doris and I were having lunch together and she had homework to do, and I said 'Do your homework. It's important. When I was your age, nobody cared whether I did it or not. If somebody had made me do homework I would have amounted to something.' And I didn't feel badly I'd said it to her," she concluded in a hostile tone, "I said it and I was glad."

Mrs. B. returned to the discussion of her feeling about her mother. "If I open up my mouth and tell her off she won't know what struck her. I guess I'll have to tell her I'm having treatments and she'll have to understand—if she's capable of it." Mrs. B.'s voice was animated with sarcasm.

The therapist questioned, "Do you have the feeling that the treatment will be an *excuse*?"

(C) *Patient is a rival with her daughter.* Sometimes the supervisor will suggest hypotheses to the therapist to prepare him for what may happen. Of course the supervisor may not always be right in his hypotheses, or there may be no chance to use a particular hypothesis in the time available for the treatment.

This preparation of the therapist is illustrated in this hour by the supervisor's comment, "Maybe one of the things about her present trouble is that she has always used her prettiness and sexual attractiveness to manage other people; now as she gets older she loses that. Meanwhile, her daughter's puberty emphasizes the fact that she may have the things that the mother has lost. Her recently increased hostility toward her daughter, as attested by phantasies of the daughter's death, may be based on this fact."⁸

⁸ This conclusion stems from the frustration-aggression hypothesis: if the patient sees her daughter as a rival, she will aggress against her. (Dollard and Miller, 1950, pp. 148-152.)

"Sure it is," she chuckled, "a good excuse! It's the best excuse I've ever had—to be able to tell her off! I feel stronger—as though I had a little more security and confidence in myself. . . . I feel as if my mother doesn't like the way I act I'm not going to worry about it! . . . I was always afraid of her before I had the treatments. If she doesn't like it I'll say the doctor said I could do it!" Mrs. B. laughed.

"Now I have the impression you are trying to bribe me," the therapist remarked. The patient admitted that he had not advised her to talk back to her mother, but the patient insisted that her mother was the cause of all her unhappiness.

"All my life I've had that switch held over my head by my mother, and I still haven't gotten away from it," Mrs. B. said. "Isn't it really my mother's fault?"

The therapist explained that it was not a question of fault but that he doubted that the relationship with her mother was the only cause of her difficulties. Then Mrs. B. began to criticize the slowness of her progress in therapy. "I haven't held out at all. . . . I told you the worst things about me. Why can't you help me to feel better faster?"

The therapist answered that she must stick to the rule and say whatever she was thinking and that she should not expect to be handed sudden solutions to her problems.

SIXTH INTERVIEW

Most of the hour was spent in contending with resistances. The patient repeatedly came back to blaming her mother for everything.

She said she kept thinking about the conflict with her mother over Doris and wondering, "How can I tell my mother to leave Doris alone? I haven't called up my mother for a week, I just can't. There is no love left." (A) And then the patient asserted that she was better and that

(A) *Good relationship with her husband would blunt the patient's rivalry with her daughter.* The supervisor commented, "Doris is beginning to menstruate and show other signs of sexual maturity." He pointed out that some mothers who are rivalrous with their daughters will even force them to wear clothes contrary to the standards of their age-mates and thus make the girls look unattractive. "The secret is," the supervisor said, "that if a married woman has her

she was talking more "freely." "I don't know if I am really better; I try harder. Maybe it's because I'm covering up how I really feel. I don't love my mother. That's a terrible thing to say, isn't it?"

The therapist answered, "Nothing terrible about it."

The patient went on, "I have no feeling about it, absolutely none. Is that good?"

The therapist replied, "I'm not here to say what is good or bad, the only thing that matters is what your feelings are."

The patient said, "I'm not afraid to tell you anything; I can talk to you better than I can talk to anyone else." (B)

eyes on her husband and not on her daughter's boy friends she will not be so much exercised about her daughter. The real basis of a good parent-child relationship is a good husband-wife relationship."

(B) *Patient's fear of talking should be labeled.* The therapist had recognized that the patient was resistant in this hour and had tried to get her to oppose her reluctance to talk. The supervisor advised pointing out to the patient her fear of talking, labeling this fear for her and showing how her stopping talking is reinforced by a decrease in fear. The therapist ought to explain this so clearly that the patient can see why she is having trouble in going ahead with the work.

The supervisor suggested, "You could say, 'I believe you are trying to cooperate, but you go on talking, and suddenly looming up in your thoughts is something vague and fearful. So when this happens you veer off and talk about something else. New thoughts that might produce fear stop coming and something else comes to mind. You are willing to tell me all your well-tested thoughts, but there is a force within you that tends to stop you from talking about these new thoughts that come up. You have to fight that force. You will come to know when "that thing" is stopping you. That force is what we are allied against.'"

The supervisor recommended using some simple analogy to make this clear to the patient. He insisted that the therapist must get the patient to recognize clearly what she is doing. The therapist wants to attach words to the clenching muscle movements in her throat when the patient is blocked, so that she will say to herself, "I'm stopping

The therapist asked, "Is there some other area besides the relation between you and your mother that you are concerned about?"

The patient said she felt guilty sometimes about not cleaning the house. She blamed this guilty feeling on the way her mother had trained her, calling it a "carry-over" from childhood.

She said, "I do have a guilty feeling a lot, a guilty feeling about not being at a certain place on time. I watch the clock all the time. I feel if I don't do something I'll get the dickens. I think it's a carry-over from being at home with my mother and I feel a little bit that way in my own home. I feel I'll probably get hell if I don't mop under the bed today. That's silly, because my husband never says anything. (C) I'm afraid to do things that other women seem to get away with. Like sometimes some of the women want to go out for dinner at night. I'm afraid to even say to my husband that I'm going out with the gang for a good meal. When I'm coming home late I'm always afraid I'll get the dickens. That has spoiled a lot of my fun. I'd rather stay home than spoil the fun by feeling guilty. My husband never complains if dinner

talking about something. What is it that I should be talking about?"

But the supervisor cautioned the therapist not to say anything like, "Your unconscious doesn't want to talk today" or, "You are unconsciously resisting me."

To sum up, then: in dealing with the fear of talking, the therapist ought to label the fear so that the patient will recognize it when she comes up against it the next time and will be able to fight harder to overcome it; to ask herself when she feels the fear rising in her, "What is it that I am afraid of talking about?" To explain the conflict to the patient and to give her credit for the positive forces she brings to it is very important; the therapist could admit that "a good first try is what you can do today."

(C) *Irrational guilt points to unknown factors.* The supervisor reminded the therapist that the patient's irrational guilt about slight and trivial failings in keeping the house clean, or coming home on time, and so on, points to a guilt about some unknown things. The therapist, noticing this irrational guilt, should ask himself, "What are these unknown factors that cause her to feel guilty about things she should really not be guilty about?"

isn't ready on time, but I still feel I shouldn't go out and enjoy myself in the afternoon." (D, E)

(D) *Therapist should pose problem of patient's sex life with her husband.* Mrs. B. was disguising the problem that she actually confronted with her husband by contending that her trouble was a conflict with her mother. Before the therapist can give a really effective interpretation of the sex approach-avoidance conflict the patient must see that she has a problem in this area. His interpretation is effective only when it latches on to the patient's motivation to explain her problem. Thus the therapist must, by dispelling competing explanations, put the patient into a learning dilemma, so that she will be in the market for a real and useful explanation. Then she can adopt the therapist's explanation and try it out.

In the case of Mrs. B. the therapist has to challenge the patient's account of her trouble as being "just a conflict with her mother" and clear away this inadequate description of her trouble before she will be motivated to accept another and more adequate explanation. She now has a pseudohistorical theory of the genesis of her symptoms. In her account of it she is sick because her mother made her that way by treating her badly as a child. This is a revised edition of the cover story.

"One of the reasons she finds it hard to be nice to her daughter," the supervisor suggested to the therapist, "is that her husband isn't nice to her. To deal with her relationship to her daughter you must motivate her to tell what her relations really are with her husband. This is a further reason for posing the problem of her sex life with her husband."

The supervisor explained that in psychotherapy we teach the patient only what he doesn't know; we neglect those aspects of his relationships with other people that he already understands adequately. Thus the therapist seems to overemphasize sex. He does *emphasize* it more than he would if he were trying to present a balanced theory of human relations.

But the therapist cannot give a neurotic patient a whole theory of human relations. He is trying to teach the patient only the part of the theory of human relations which he does not have. A therapist

The therapist, not understanding how these things could account for the patient's strong guilt, asked Mrs. B. what she felt guilty about. Mrs. B. answered that she felt she really had no right to go out and enjoy herself; she should be home scrubbing floors or cooking. Even before Doris was born, she said, she felt guilty about her activities in an

does not tell a woman, for instance, that she is bound to her husband because she shares a status with him or because they have children together; nor does he belabor the point that eating together reinforces their tendency to live together. The therapist ignores the fact that there are couples with a good sexual relationship who break apart on differences in status or because one partner has criminal tendencies.

If the therapist tried to present a balanced theory of human relations, giving as much emphasis to the parts the patient already knows as to the parts he does not understand, the neurotic would take advantage of this reasonableness to deny the importance of the sexual aspects. The neurotic would say that if everything else in the marriage went right, the sexual part would go right, too. For instance, Mrs. B. thought that "love" brings a good sexual tie. It is really the other way around: a good sexual tie spreads its benign effects over the other aspects of life. The therapist points to the goal in a marriage partnership of getting sexual, social, and economic rewards in one package. This strengthening of the marital bond by basic rewards not only offers a situation for greater individual contentment but is, obviously, fundamental in the preservation of family life in our culture.

(E) *Patient's blaming others explained behaviorally.* The patient was blaming her mother for stealing the daughter, when, in point of fact, the patient had actually deserted the daughter; she blamed her mother for the failure of her sex life with her husband, when, in fact, she herself was mainly responsible. These are examples of projection—i.e., of blaming someone else for what is really one's own fault.

The supervisor pointed out that projection of blame is a kind of solution of a conflict. The honest way of describing the conflict would be to say, "I feel guilty because I hate my daughter." Those

amateur dramatics group. She went out several nights a week to rehearsals.

The therapist asked, "Whom did you go out with in the drama group?"

statements would evoke considerable anxiety in the patient, so they are not uttered. Since, however, the hostile and sexual motives are still active, they still arouse guilt in her. It is this guilt she must escape.

She has had training in not feeling guilty when others are to blame. Sometimes they really *are*. Saying "It's her fault" is accompanied by learned tendencies to relax. To say, "It's my mother who has caused the trouble," gives the patient a seemingly reasonable account of everything and produces the desired decrement in anxiety. The projection sentence "It's my mother's fault" is therefore strengthened both by the reduction in anxiety and by a reduction of the learned drive to have an account of one's behavior.

The supervisor pointed out that in the case of paranoia there is another element. According to Freud (1925, Vol. III, pp. 444, 448), a homosexual sex-fear conflict is a precondition of a paranoid solution. Most persons in our culture have learned a fear, approaching horror, which opposes all homosexual responses. If a homosexual drive is the subdominant drive in a conflict pair and fear is the other, then this sex drive exists not only as a primary drive within the body but also is conditioned to cues from people outside. Appropriate persons "outside" arouse a secondary or learned drive. Primary drive cues and learned drive cues are organized in a single pattern. If another person were to try to seduce the subject, it would be natural for the subject, if reluctant, to blame the other person and call him the seducer. Now if the internal cues of a homosexual primary drive appear with little or no outside provocation, it is easy to generalize the blaming response from the total cue pattern to the internal homosexual cues appearing by themselves.

Thus it appears that a person, himself motivated homosexually, can surmise a seductive intent in others where none exists. The paranoid reduces his guilt at homosexual wishes by the comforting transfer of blame.

Mrs. B. replied that she went out with many of the women—also with the men in the group. (F)

"I was a good actress," Mrs. B. said. "I always learned my part before any of the men learned theirs. But I even had a feeling when I was—before Doris was born—that I had no business out here enjoying myself. (*Short pause.*) And when we first moved out to where we're living the school was about eight blocks from where we lived. And it . . . we'd about . . . ah . . . Flushing Boulevard, I don't know whether you know that neighborhood or not . . . and . . . ah, there's a lot of traffic out that way. And one morning—and Doris used to walk to school with the other kids in the very beginning. And one morning one of the kids got run over. And after that experience I had to drive Doris to school four times a day. Ah . . . for about five years I did that religiously, in all kinds of weather." Mrs. B. then came back to the theme that she felt guilty about going out and having a good time.

The therapist asked, "Are you worried about what other people might be thinking when you go out with your drama group acquaintances?"

"What do you mean?" asked Mrs. B.

"Well, you say you feel guilty. Guilty about what? Before whom?"

"You mean guilty about my husband?" said Mrs. B. "Yes, I think that might be true. Maybe I feel I shouldn't be enjoying myself. . . . I feel guilty about—lot—about a lot of things. It's silly. I feel guilty about asking my husband for money. Other women aren't afraid to. I don't know why I should feel that way. I'm afraid to ask for money, but when

(F) *Challenging the implausible moved the treatment forward.* The therapist had resisted the patient's displacement of blame onto her mother, and because he did this the patient went on to tell how she had "gone out with some of the men" in the group after the rehearsals. The supervisor pointed out that if the therapist had not resisted her displacement of blame to her mother, the patient would not have gone on to tell him this. The new information was evidence of the success of the therapist's tactics.

The patient's guilt about "going out" was first blamed on excessive training by her mother. When this was challenged some other explanation had to be given.

I do he has never refused me. He is certainly good-natured about things." (G)

The therapist reminded Mrs. B., "Now, there's more in marriage than money. And every time you tell me about your husband and your married life, you seem to be telling me about the financial side of it. I wonder why that is?"

Mrs. B. replied, "Well, maybe I feel I should have married a man with more money. But I loved Bob. And I still do. And he's sweet—he's older than I am. (*Clears throat.*) He's . . . ah . . . oh . . . when we first got married, he was quite selfish because he had been a bachelor. . . . Now he's more considerate. He's sweet, and he's understanding. . . . But he restrains me a lot too. Bob does. He restrains me from a

(G) *Patient needs to know her marriage can be better.* Mrs. B. blamed her husband about being close in money matters, although she felt she had no right to blame him. The supervisor pointed out, "She may have a right to hate him for interfering with her sexual life, but she might not realize that. So you could say to her something like this, 'Some people don't know what a good marriage can be like. People don't talk about it very much, and so you never get to know how they feel.'"

"I think she needs a kind of permission. You could say, 'There are a good many people who don't achieve what they might in marriage and are bitter about it without ever knowing why.' This kind of interpretation would be permissive of thought and behavior. It would allow her to try out new responses, for instance the thought, 'Why can't my marriage be better and more satisfactory?'" The therapist's aim would be to "create hope that there was a rewarding way out of her neurotic impasse." (See Dollard and Miller, 1950, p. 316.) An interpretation is given not merely to have some kind of account of the matter at hand, but is, instead, an intervention that should point to new ways of responding. The patient can then try out these new ways of thinking and acting and see how they work. If the interpretation is apt, the patient will be rewarded for trying these out and will adopt the interpretation. But the patient's own experience, and not the therapist's authority, will be the basis of adoption.

lot of things that I would like to do. I would much rather go out and have—do a lot of—have a lot of fun, but I can't do it." She complained that he seldom wanted to go out to visit other people in the evening.

The therapist asked how Mrs. B. felt about being restrained by her husband. She answered that she'd just forget about it; she wouldn't make an issue of it. She wouldn't dare to tell him she hated him. He probably hates her sometimes too, she said.

The therapist asked why her husband would hate her. Mrs. B. replied, "I think Bob could really be angry at me for—I mean getting—saying a lot of stupid things. Probably wonders how the de'—devil he ever sat and—I mean ever—how he ever married a girl like me."

The therapist announced, "Our time is up for today."

SUMMARY OF THE FIRST SIX INTERVIEWS

At the beginning of the treatment, Mrs. B. presented her cover story that her difficulty stemmed from a lack of closeness to her children and from resentment toward her mother. In her account, it was her mother who "stole" the children and was responsible for Mrs. B.'s estrangement from them. According to this cover story, nothing was wrong with her marriage; the relationship with her husband was good.

The treatment did not "get off the ground" until the therapist challenged this account. His first challenge (in the fifth interview) came as he noted that Mrs. B. had not said anything about her relationship with her husband. The therapist expressed incredulity that the patient's relationship with her mother was the only important area in her life.

Mrs. B.'s response to this doubt of her cover story was to tell the therapist, in the next hour, that she felt guilty about not doing her housework as well as she ought to. The therapist saw that this guilt about housework was displaced—that it sprang from guilt over something else—and he posed the question whether she felt guilty about something else. This interpretation represented an attempt to deal with a *sociological rationalization*—in this case an explanation in terms of housework rather than of guilt that was produced by psychological conflict. This interpretation was therefore the first in a series of interpretations that removed sociological rationalizations and prepared the way for psychological explanations of the neurosis.

The therapist had, so far, not succeeded in posing Mrs. B.'s problem as a psychological dilemma. Mrs. B. still had not abandoned the explanations that her mother was to blame, that the trouble was that she was "bored with housework," and so forth. For further progress to be made, she had to be induced to abandon these false "sociological" explanations.

THE CASE OF MRS. B.: Therapy Focused on Relationship to Husband

SEVENTH INTERVIEW

The patient announced at the start of the hour, "I am tired, I can't tell you anything." She said she was very upset about Doris, who is sick. She was afraid her mother was going to blame her for the way she was handling Doris.

Then Mrs. B. began to talk about her son. "My mother keeps bringing up the fact that Paul is getting a scholarship, but that *she* sends him pocket money. And she has always sent Paul to camp each summer since he was eight—and she keeps rubbing it in that it's she who sends him to camp and all that. But Paul doesn't seem to be so very close to her; Doris has got the brunt of her attention."

Mrs. B. complained her husband was not sympathetic, that he was irritable. "I get very annoyed with him. . . . He was away all weekend, and I was alone. Men are awfully selfish, I think. They only think of themselves. A woman is so different. I hate men." This outburst was followed by the statement, "My insides are making somersaults. I should have taken phenobarbital. I want to get home."

The therapist interpreted this as a desire to escape the treatment. He explained to her that she was afraid to say something: "You get an uncomfortable feeling when you're about to say something that would make you anxious."

The patient replied that she had told everything. Next she argued, "These things are personal; they're not interesting to anybody but me;

I can't tell you these things. If I told you, you'd probably think I'm the world's worst person. I'm frightened."

The therapist insisted that everything that occurred to her was pertinent to the treatment and must be said. Mrs. B. confessed then that several years previously, while she was a member of an amateur dramatics group, she had gone out after their rehearsals to have a little fun. She refused to elaborate on this, however.

The therapist then pointed out to her the disabling features of her neurosis and tried to utilize this to motivate her to speak whatever occurred to her, saying: "Let's take a look at you compared to what most other people are like. You have periods of depression when you sit down and cry, and most other people don't. You have the feeling that you can't do things and won't try, but most other people do try. You start something and leave it unfinished; most other people don't. You have a feeling about being late in coming home, and most other people are not so upset if dinner is late or they skip sweeping under the bed some day. You have a way of blaming things on other people—particularly your mother—which is unusual and most other people don't do so much blaming of others. In all these things you are different from the average run-of-the-mill person.

"These are the things that have been bothering you. They bothered you enough to make you come for treatment. We are offering you treatment on the understanding that you do not keep out some things and say they can't be talked about. If you feel you want to go on the way you are the rest of your life it is up to you. If you go on with the work here you may be in a position to have a more satisfying life. But if you prefer to stay the way you are, you can—or you can do some hard work and get better."

This speech seemed to motivate the patient. She admitted the therapist had pictured her accurately. Then she went on to say, "Maybe my husband has a lot to do with it. I keep blaming my mother so I might as well blame my husband. Maybe it's because he is older than I am I did a lot of things I shouldn't have done. Maybe I needed more freedom and I didn't have it. Maybe Bob is like my mother. Maybe before I was married I didn't have enough fun. Can't you guess?"

The therapist insisted that she say what was on her mind. Finally Mrs. B. was able to say: "I guess I used to like to drink a lot. . . . With a few drinks under your belt you do a lot of things that you don't know

why you're doing them, but you do them anyway. My husband never knew I drank as much as I did. I don't think he knows to this day. It always felt wonderful and relaxing and nothing to worry about, and it was a good feeling and I liked it." (*Pause.*) "I can't tell you any more." (*Pause.*) "I did some foolish things when I used to drink a lot. . . . I don't see what this has to do with the way I feel. I still don't know what these things have to do with the important things that are bothering me. . . .

"I would wait until lunch time, just to get out of the house and away from my mother. I would go out and enjoy myself—getting away from that awful house. Even though I drank they never knew I drank. . . . But I liked it and I did a lot of it. . . .

"Then I got mixed up with some people—men—and it was fun. I enjoyed it. I guess when you are drinking you don't care really. I did a lot of foolish things. That's really about all that I've done, all that I was afraid to tell you. . . . It was a wonderful escape. . . . I don't think I could do it today or any more. . . . When I felt as though I were slipping, I stopped it. . . . That's what I've been holding out on."

The therapist pointed out that this hour gave a good example of the hard work involved in the treatment and of how Mrs. B. must fight against the fear that blocked her from continuing to talk. (A)

Comments at Supervisory Session

(A) *Comment on the hour.* During the entire hour the patient had been trying to make, and to avoid, this confession. To avoid it she had wanted to leave the hour, and to declare certain facts "personal" and out of bounds. Her anxiety mounted as she approached her disclosure. Had the therapist been any less firm in his attitude the truth would not have been told.

In the previous hour the therapist had "failed to understand" the patient's senseless guilt about housekeeping; and had correctly surmised that the guilt arose from some other source. Then, he aided the patient to tell the truth. The infidelities were an adequate reason for concern—the housekeeping details were not. This type of inference arises directly from a knowledge of the mores of our society.

In advising the therapist on next moves, the supervisor com-

EIGHTH INTERVIEW

The patient reported in a defiant voice that she had told her mother off. "We had a little spat, but I don't think it amounted to anything really. I guess I sounded awfully fresh, because I went home and my husband gave me the devil and my daughter gave me the devil for being so fresh, but I don't care. It was out. . . . Then, next night my husband and I were going to a dinner party. I had a drink before I left the house and I was feeling courageous because I had told my mother off the day before (A) so I thought I could tell him off too. I told him about a lot of things that I'd never said before. I don't care, I said it and I was glad.

"And two days later my daughter spent the week end at my mother's house, and Doris came home and said, 'Grandma said if you ever talk to

mented, "There is no use in crying over spilt milk, but there is use in learning how not to spill it." The supervisor's position is that the therapist must reduce the patient's guilt so that she can talk, but the therapist asks the patient carefully to canvass the episode to find out the motives that were operating in it. Unless the patient uncovers them they can still operate (Dollard and Miller, 1950, pp. 316-318, 321-328).

(A) *Therapist advised to stick to his theory of the case.* Commenting on the patient's statement that he had told her mother off and the patient's blaming the therapist for supposedly giving her permission to do this, the supervisor said, "Your discussion with her seems to concede that her real problem is with her mother, which we don't think is true. She is going back to her old theory which you have challenged once. Apparently she comes to therapy in order to be able to attack her mother and then to blame you for it." The therapist was advised to stick to his theory of the case, not to be diverted from it by the patient.

Of course, the patient's relationship with her mother is involved in her life, but she overemphasizes it in order to escape the necessity of talking about the relationship to her husband and about how she has neglected her children.

her that way again she will cut you off from her will completely.' (B) It is discouraging if I say things because I get repercussions all the time. I don't know whether it is doing me any good or not. I feel all this treatment is a waste of time because I am banging my head against a stone wall."

The therapist asked, "Why did you think that the treatment recommended that you talk to your mother as you did? I only told you that I was surprised that people could walk all over you."

The patient answered in an embittered tone, "I could never talk back but now I feel a little bit more encouraged. Why should I get slapped back? That is what I am confused about. Probably my mother didn't know I had it in me because I hadn't talked like that before. I thought I could say my little piece and she would not say anything but let it go at that. . . .

"When I told my husband off I said, 'You forget that I helped you out when you needed it badly. Now that I'm older I want a little more from you.' He said, 'Here, take my money and I'll go in ragged clothes.' Such a stupid answer! I didn't complain about anything. I go without everything. I want to feel just as important as the next one. If I do buy myself anything I look for bargains; I don't buy good things. I suppose I could go downtown to buy a dress or a hat and see what would happen. But I don't think I would have the courage to do it. It's my own fault; I made life too easy for him. When I got married my family gave me a lot of money. I turned it over. I feel as if I should be indulged more; I feel that I should have a little more than I have, but I'm afraid." (C)

(B) *Therapist must know what the patient's life conditions are.* The supervisor pointed out that the therapist must know how much money is involved in the patient's mother's will. "Otherwise he cannot evaluate properly the motivation for the patient's behavior. If the sum of money in the will is considerable, then it may be realistic for the patient to show quite a bit of concern over her mother's threat." (It turned out that the mother had little money.)¹

(C) *Patient's quarrels over money express her resentment about other things.* The supervisor called attention to the fact that the

¹ The importance of life conditions is pointed out in Dollard and Miller (1950, pp. 339-342).

The therapist inquired whether they really had enough money to live comfortably. Mrs. B. rejoined, "I would never discuss money with anybody. I thought that would be a deep, deep secret." (D)

quarrels over money do not seem sufficient to explain the bad relationship between Mrs. B. and her husband. There must be something else involved because they are relatively well-off financially. The patient has turned from an explanation of her problem in terms of her mother to an explanation in terms of her husband, but stresses the money aspect. Behind this there lies the idea, "He is cheating me." And behind this notion lies her own conflict. In quarreling about money with her husband she is quarreling about the wreckage of her marriage. This symbolizes her sense of loss, and the bitter quarrels about money express her bitter resentment against him on other grounds.

The supervisor told the therapist, "You should lead her to ask herself, 'What happened to my relationship with my husband? Why do I feel so bitterly toward him?' You could say, 'It must be that your husband is disappointing to you in some other way. I can't imagine anybody feeling and talking as you do who has a really good relationship to her husband.' Probably her hostility stems from their miserable life together."

The supervisor reminded the therapist, "If she really faced up to her husband, not on the money score, she'd have to face the fact that because he disappointed her she didn't take care of her children properly. These are the things she has to face up to. To get her to go back and canvass her life would take many months. The best we can do in the time available is to have her consciously confront the fact that she has a problem with her husband, a sex problem. Maybe she should be divorced, but that would be for her to decide. They may have as good a chance of being happy with each other as they would with anybody else."

(D) *A secret that protects a secret.* According to the supervisor, the patient's comment, "I would never discuss money with anybody. I thought that would be a deep, deep secret," must really represent her reserve about other tabooed topics. This is a secret that protects a secret.

The therapist said, "The last time I saw you I pointed out how you differ from other people in several ways. I have the feeling that you then took this as if you feel that I had said, 'Change this, and change it now.' For example, I pointed out about how you said your mother walked over you and you never talked back. I pointed out that you said you were overconscientious about the house." (E)

Mrs. B. answered, "But I figured it all out in my own way. It is not because you suggested it. I worked it out; I talked to myself. I said, 'Why should I knock my head in cleaning up this house? Who tells me I have to do it?'"

Then the patient went back to talking about her daughter. The previous week end, she reported, she hadn't gone to New Hampshire with her husband because she didn't want to ask her mother to take care of the children. Then, at ten o'clock Sunday morning, Doris said she was going to spend the day with her grandmother. Mrs. B. wondered why her daughter "prefers her grandmother to me." The therapist hinted that maybe Mrs. B. had not always been too good a mother. She agreed that perhaps she had not. The therapist said, "You told me that you are now trying to have a better relationship with your daughter."

(E) *Supervisor reacts to cues missed by therapist.* A good example of how the supervisor may react to cues that the therapist has not reacted to is given in the supervisory session of this hour, in which the supervisor pointed out that the patient is chronically irritable and aggressive. Her aggression against her mother, her husband, and her children shows this. This was also revealed in her reaction to the therapist's statement that she seemed not to be reasonably assertive.

This irritability and aggression implies that there is something here to be explained. That is, the supervisor has taken note of a cue of incongruous or mysterious behavior on the patient's part. The supervisor said, "Does she realize that she is very bitter and hostile, very resentful of other people's control over her? What is it that she is not getting that makes her feel so cheated and produces this feeling of resentment? She picked up your suggestion as permission for aggression. That is what is called acting out instead of thinking out,

NINTH INTERVIEW

Mrs. B. reported, "I've been feeling very well, up to last night. Then I got nervous and felt as though something were going to happen to me. I haven't had a thing to eat, I was too nervous. I'm depressed." She went on to say, "Doris is going to a dance Friday; I got her a dress for it. She seems to be getting a cold. I hope she doesn't get a cold so that she can't go to the dance."

The patient reported a number of arguments about money with her husband. The therapist pointed out that these arguments could result from dissatisfaction in other areas of the marital relationship. (A) The patient resisted this interpretation except for admitting that her husband does not want to do social things she would like to do. She

and she always does it disproportionately.² What is she so bitter about? She doesn't realize how bitter she is. She views herself as an inexpressive lamb, but she is actually an embittered person. She feels cheated. She has to see that she is bitter, but that she has been made embittered, that she is not bitter by nature.³

"But this woman has a lot of strength. Somehow or other she has held her life together. You could well express some admiration of her strength too, when you pointed out that she has been embittered."

(A) *Money may be symbol for love.* The therapist, prepared by earlier discussion, here questions the economic interpretation of the patient's unhappiness. Realistic difficulties about money do play a role in the patient's life but she has greatly overestimated their effect, as most people do. Complaints about lack of money can be disguised requests for "love." Carelessness with money can be a form of aggression against the partner. Parsimoniousness can represent an unwillingness to give more in what is already felt to be a bad bargain. Mrs. B. and her husband argue about money instead of recognizing difficulty in really loving each other.

² "Acting out" is the opposite of stopping-and-thinking, in which people are given a great deal of social training.

³ The therapist's interpretation ("You sound embittered") would be an example of what Dollard and Miller (1950) called "Method III: Teaching new verbal units." See pp. 293-301 of their chapter on labeling.

related that they never speak to each other in the evenings. They have "nothing to say." (B) She turned the conversation again to the quarrels about money between her husband and herself.

TENTH INTERVIEW

The patient reported that she had a blank mind and that she felt as though she had made no progress at all in the treatment.⁴ Then she said, "I think what I need is a rest. I need to get away from it all." She complained that she was bored with housework.

The therapist pointed out, "When people feel they're not getting just rewards for their work, sometimes they get fed up." The patient replied that it was just that her husband didn't want to go out as much as she did. The therapist answered, "How about staying home together? Are you bored with your husband?" (A)

(B) *Sex fear may generalize to talking.* The supervisor explained that the anxiety attached to sexual intentions and acts spreads backward to talking. Talking is a frequent preliminary to love-making and any unguarded conversation could get around to personal matters—thus fear generalizes from the sex act itself to responses preceding it.

(A) *The spouse phobia.*⁵ Here we have an excellent example of what might be called the husband or wife phobia. It is a quite common phobia. The patient regards her marriage as an incestuous situation. Viewed currently, such boredom is a phobic reaction, and in terms of its origin, it is a continuation of the incest taboo. The therapist remarked that the patient may be dissatisfied with her husband's sexual responsiveness. The supervisor replied, "We may not be able to do much about him, but if her fear is reduced it might help them. However, as one partner becomes more appetizing the other may become more frightened."⁶ The boredom that the patient speaks of is probably a vague fear, although there may be a number of different sources of excitation. It could also be that the patient resents her husband, and that she would like to have him out of the way and

⁴ See the discussion of "the blank mind" in Dollard and Miller (1950, pp. 255-256).

⁵ The "spouse phobia" is discussed in more detail in Chapter 9.

⁶ Dollard and Miller explain this in terms of the approach-avoidance conflict (1950, pp. 357-359).

The patient said, "Supposing I am, what do I do about it?" Then, "I really think I need a change, I'm awfully tired out." (B, C)

have a man who would really please her in his place. Another possibility here is that there may be an element of dependence. The patient seems to feel, "Without my doing anything myself or taking any of the risks in the relationship, *he* should please *me*."

The supervisor told the therapist, "I think you can render her quite a fundamental service if you put your finger on the point that there is fear about sexual things carried over from earlier life into marriage. Household reactions originating in the past do persist, but since conditions are now so different, why do they become accepted as appropriate? Is she really taking the chances in relating herself to her husband that would help her get over the fear?"

"Almost all married people will see some degree of this boredom reaction in themselves. The point is that if one has routine household duties to perform and the hope of sex rewards does not appear as a secondary reward in the work sequence, then one has to carry on the work from conscience pressure alone. Anticipation of sex gratification would help to reward her for her work, over and above the escape from conscience pressure. She is now bearing a lot of tension. Perhaps she mistakes fear for boredom."

(B) *Clear cues for bringing out the sex-fear conflict.* The therapist asked, "Would there be any danger in bringing up the sexual matters since so far she has refused all my efforts . . . all my hints that her problems may lie in the sexual sphere?"

The supervisor said, "You have a good, clear cue for bringing up the sexual side because of the boredom she speaks of. If you can bring to mind the times when you yourself have been under intense libidinal excitation and have been anticipating sex relations with someone, you can see what the possibilities of marriage, ideally, are, and you can see, by contrast, how far she is from realizing these possibilities. And yet, no one would mind if she and her husband were really happy together."

"You do not run any danger in bringing this up with her. She is not shy. She is playing a game with you, and in brief psychotherapy you do not have time to wait her out. I think you would run

ELEVENTH INTERVIEW

(The reader may refer to a verbatim transcript of this hour in Chapter 8. This hour will be presented in full because of the many interesting technical problems that it demonstrates. The therapist met these prob-

very little risk if you say that she is afraid of sex relations with her husband. You will have a chance to tell her something that might make a difference in her life."

(C) *Extramarital sexual activity, with boredom in marriage, has to be explained.* It will be remembered that the patient reported some extramarital adventures with men "at some bars." The supervisor remarked that patients will say they have no sex fear and, to prove it, will present a fine record of seductions outside of marriage. But "one swallow doesn't make it summertime" as the proverb says. These seductions always occur in situations where the partners don't stay together. For some reason, not too clearly understood by us, and baffling also to Freud, the repeated sex acts of marriage tend to build up a mild phobic reaction between spouses. Perhaps, for instance, living in the same house tends to remind of childhood conditions when one never had sex relations with persons in the same house. Extinction of sex fear in marriage doesn't seem to work out well, perhaps because the partners are not aware of the nature of the fear; they assume instead that the occurrence of the marriage ceremony will cancel the long-standing overlearned fears of sex which they were so well aware of during adolescence.

"This patient's depression may stem from her hatred. She hates her husband because she doesn't get sexual satisfaction from him. When you are with someone you hate, you are afraid you might suddenly come out with your full hatred—a slight stimulus might evoke a hostile reaction that would, through the tit-for-tat mechanism, evoke stronger and stronger reactions. Her guilt may be evidence of her reaction to this latent aggression.

"The sex activity outside of marriage has one positive aspect; it shows that the patient doesn't lack capacity for sexual response. This fact taken together with the 'boredom' in marriage suggests here is a situation that must be explained."

lems with considerable skill, and the treatment moved forward, as can be seen in subsequent hours.)

The patient complained of unhappiness and boredom. (A) She said, "My life is very boring and very dull, but it really is my own fault. I really should go out and get a job and work, I think, so that during the day my mind would be occupied—my time is taken up at night—I'll be very contented to sit home and do nothing. . . . I should be so busy during the day that at night I won't mind staying in and being bored or leading a quiet life. . . . But I'm not qualified to do anything really—I mean to get a job—I could only work in a gift shop. . . . I haven't taken any courses in any secretarial work or anything like that. But I suppose I could do it. Now I could take up book-keeping or typing and shorthand. . . . I was thinking about doing that. . . . (B)

"I don't know what's the matter with me. Is it that I have life too easy that I complain about it? I have two lovely children, I have a

(A) *Boredom points to an unconscious need.* Boredom, without special reason, points to an unconscious need influencing the patient. From the outsider's point of view, she has everything necessary for a happy life—a home, a good husband, children; but from hers she lacks something necessary to happiness. Yet, she does not know why she is bored and restless. This is a clear-cut behavioral demonstration of the need for a concept like the unconscious.

(B) *Patient thinks a job might help.* The supervisor noted the patient's wish to go out and get a job to escape from boredom. He commented: "She attributes her boredom to lack of something to do. A job might, indeed, get her out of the fear situation, and be rewarding because of this. It would give her new thoughts and duties to distract her from the sex conflict, and these acts would be rewarded by escape from the anxious brooding. Finally, going out to work would bring her in touch with other men, and this might be rewarded by some reduction in secondary sex drive. On the other hand, seeing other men might arouse stronger sex motivation and put her in worse conflict than she now feels. And in the end it would leave her stuck with the same husband and with the same sex approach-avoidance conflict toward him which she now has."

wonderful husband, I have a lovely home, but I'm not happy. That doesn't make sense. . . . Is it because I have things too easy that I'm discontented? If I had it harder would I feel that I shouldn't complain about anything? . . . I entertain when I want to . . . but I'm not happy and I complain all the time. . . . Why should I feel that I'm discontented, that I'm looking for something all the time? . . . I have no right to, really, . . . many people are worse off than I am. . . . Am I making a mountain out of a molehill?"

The therapist replied, "There's something in this picture which seems to be missing. I mean you mention these things that are seemingly satisfying and yet you are not satisfied."

The patient referred to her husband: "He seems to be very contented with the life he . . . leads. I don't interfere with his life. He seems to like to come home and stay home and relax . . . I . . . can't interfere with that. It wouldn't do me any good if I tried. We are two very different personalities. . . . He's very placid and reserved and I'm just the opposite. I'm happy-go-lucky—I mean I used to be happy-go-lucky. . . . I like to have fun. I don't feel as though I'm old . . . too old to enjoy life, but he likes . . . the quiet life." (C)

The therapist inquired, "This difference in personality hasn't been bothering you . . . all through the last sixteen years or so?"

The patient said, "Yes, . . . we can be visiting and I'll be having a good time and all of a sudden he'll say, 'Come on, let's go home.' . . . It's been going on for years. . . . If we're invited out and he's tired, we don't go. . . . But I guess I can't be a playgirl all the time. . . . I feel as though I want to have fun. . . . Is that wrong?"

The therapist answered, "You have a right to that kind of thing." (D, E)

(C) *Patient tries a constitutional explanation.* Here the patient tried out a personality-type explanation of the difficulty between herself and her husband. The evidence that the patient is neurotic is too clear for this explanation to be persuasive. Note that the patient uses this explanation as a dodge to escape recognizing the real nature of her relationship to her husband.

(D) *Patient has the right to solve her problem.* The supervisor did not approve this statement because the therapist is rewarding

Mrs. B. described how she and her husband went away on a vacation for four days and all she did "was sit on the porch and read. . . . I can do that at home, and people said, 'Oh, you must have had a wonderful time on your vacation,' but . . . I hated every minute of it. Of course, I didn't say anything to him. . . . (F) I hated it and I won't go away with him any more, and I can't go alone, so I'm stuck. So I guess for me the only way I can go—I mean get away—is to go with him and do what he wants to do.

"You see how different we are? . . . Maybe he holds me down; maybe I need that sort of thing. . . . I thought being married would be different. But it hasn't changed a bit. I mean so far as pleasure and

the patient's rationalizations. He said rather that the therapist should label the rights the patient does have. The right to solve her problem and to use her marriage is the only certain right that she has, and the therapist could well point this out to her. He might say, "You have a right to get fun out of life, but not to have someone give it to you. You can't enforce a right to have someone impose sex gratification on you." Or the therapist could have iterated, "So there is something missing from your life. What could it be?"

(E) *Therapist should focus on problem of marriage.* The observation of the supervisor was that the therapist, to some extent, is still dealing with marginal problems, such as whether the patient should go out and get a job, whether the patient has a right to get general fun out of life. He should, for the most economical use of time, focus on the marriage problem and try to get across to the patient a first approximation of the notion that there is an anesthetic area in her life that has to be explained. The patient will bring up her sexual problems if she is made to see that there is something to explain. The therapist has to keep attention focused on this area if the patient is to be helped to see that this is a problem.

(F) *Not just boredom, but discomfort.* The supervisor added: "It is well worth noting that the vacation with her husband resulted not just in boredom, but caused new active discomfort to the patient. Being alone with her husband more of the time probably increased 'temptation' and temptation in turn tripped off stronger fear. Result: increased conflict and misery, as reported."

enjoyment. . . . He is so good that I can't go. . . . I can't disagree with him." (G)

The therapist asked whether the patient's going out to the amateur dramatics rehearsals, which she had reported doing in the past, had any relationship to this "having fun" that she talked about. He said, "When you used to be active in that amateur dramatic group . . . you were going out and having fun?"

The patient replied, "It made me feel I could have fun one or two afternoons or evenings a week, and I could sit home the other evenings. . . . But I feel he is entitled to living the kind of life he wants to live. . . . He puts in a hard day; he's tired. . . . I'd never deprive him of going to bed at nine o'clock or ten o'clock. . . . Of course I feel terrible, but I don't say anything about it. We refuse a million invitations on account of him. Is it wrong to feel that you still want to have fun in life? . . . He is good." (H)

The therapist asked, "How do you mean?"

The patient answered, "He's reliable, he's honest, he's a hard worker. He's a homebody. . . . Maybe I'm not mature."

(G) *Patient is depressed because of hatred toward her husband.* The origin of the patient's depression may be here. The supervisor pointed out that this statement of the patient's could be paraphrased in this manner: "He takes care of me so I can't hate him. . . . He is a good parent to me, so I must not hate him."

That may be where the depression comes in. The patient hates her husband for the privation he forces on her (as she sees it), for holding her in the anxiety situation, and for blocking sexual expression outside; but, on the other hand, he supports and cares for her and she fears to lose him. The depression indicates a situation of hopeless hatred and hopeless conflict.

(H) *Limited social life not the cause of patient's boredom.* The patient tried here to get the therapist to agree with her notion that limited social life is the cause of her boredom. The supervisor admitted that "There is some reality in this explanation, as is always true with a rationalization. However, this is not the fundamental answer to her dilemma. Only a real improvement in her sex life with her husband can solve her problem."

The therapist inquired whether these things she had mentioned as the good points of her husband were the only things she would expect from a husband.

Mrs. B. answered, "No, I think a husband should be as excited to do something as the wife should. I feel Bob should feel like I feel about having a good time, about going out and being with people. . . . He should be as congenial as I am. Even when we were younger—I mean even before we were married and we were engaged, it was the same way, although I always figured, well, he had a hard day the next day and I would not interfere. . . . He never stayed up past midnight. . . . How can I do anything about it? . . . I certainly couldn't say to Bob, . . . 'I'm going out to have fun.' . . . As much as I would probably love to do it, I would not do it. Is it because I feel that I missed so much when I was younger that I feel that now I want to do things I didn't do before? . . . I think I never really had a chance to go out. . . . It sounds silly to even talk about. . . . Can't do anything about it anyway. I sound like a child. . . . Once you start your life . . . you can't change. Especially your married life. I've never told Bob how I felt about this because . . . it wouldn't do any good." (I)

The therapist pointed out, "You say yourself, again and again . . . it doesn't make sense."

(I) *Analysis of the displacement mechanism.* There is undoubtedly a difference between husband and wife in level of interest in social life. We believe, however, that this difference would not seem so punishing to Mrs. B. if she and her husband were actively in love. As in the case of the money problem, she overemphasizes differences in sociability in order to conceal the sex problem. The true problem therefore lies in the sexual realm. Here also the patient assumes that her husband is to blame. Although she herself is passive she displaces the responsibility for the failure of their sex life on him. The supervisor asked: "After all, one might ask does she have the right light in her eye? Is she doing what she can to arouse this man, or is she assuming that he will bring her gratification despite her reticence? People who have fun sexually are active, doing their reciprocal part in sexual interaction.

"This displacement mechanism can be analyzed behaviorally. The

The patient answered, "How can I go back to Bob and say, 'I want to go out tonight. . . . I want to have fun.' . . . What am I going to do, go out by myself? . . . I keep asking myself, . . . what do I want? . . . It sounds stupid, doesn't it?"

The therapist responded, "It doesn't sound stupid; it just sounds like an incomplete picture to me." (J)

The patient continued, "Well, maybe it is because I don't have enough to do. . . . I feel that I'm not getting everything out of life that I would like to."

"What would you like to get?" the therapist asked.

conflict is within her, within the patient. If she faced it, she would have to say, 'I'm afraid of my sexual feelings for my husband.' But she actually says, 'He is responsible; he doesn't do anything.'

"To elaborate on this: The subject could say, 'I have strong sexual feelings that are excited by my husband. They produce intense anxiety in me, so that I am in conflict. Should I try to seduce him, should I let him know what I want? Will he think me nasty if I am sexy?' Talking about sex to oneself increases drive strength through the arousal of learned drives. Furthermore, strong sex feelings kick off strong fears. In this dilemma the patient was led to say, 'I am miserable, but nothing is called for from me, because the more I do the more miserable I get.'

"She blocked out all the description of her own sexual feelings and her own anxiety, but she still had to explain her misery. It still might be her own fault. Then when she said, 'It is his fault,' that statement was reinforced because it excused her from activity and thus provided a partial escape from conflict.

"Notice that she displaced the emphasis onto the night club, to going out in general, instead of talking about going out to get sexual gratification. If she had said, 'I want sexual gratification, I'm going out to get it,' that would have aroused anxiety in her. So she said, 'He should give it to me.' And that became, 'He should give me a more exciting life.' This last statement greeted the therapist as the survivor of a complicated series of reactions."

(J) *Therapist notes incompleteness of account.* The therapist followed the general instructions and here noted a lack of a complete

Mrs. B. said, "That's what I'd like to know. . . . What do I want?"

The therapist inquired, "When you were engaged to your husband, . . . was there something you were hoping for that might compensate you for some of the socially unexciting times?"

Mrs. B. answered, "I was madly in love . . . and I adored him. . . . I didn't look for anything else. He was sweet. . . . I didn't need, I didn't want anything else. He was thoughtful. . . . Bob is very secure. . . . Nothing seems to bother him too much. And he has had a tough life, too, because he worked his way through college. . . . I always felt that Bob was the old reliable . . . he was always there. . . . He still is . . . today."

The therapist pointed out, "You sound as if you were disappointed."

The patient continued, "I don't know. Maybe it is because he is older. . . . Maybe if I had married someone younger that wasn't so set in their ways. (K) Bob is a lot like I remember my father to be. He had a wonderful disposition, easygoing, reliable."

The therapist insisted, "Isn't there something that one expects from a husband that one doesn't expect from one's father?"

Mrs. B. replied, "Romance? That's when you're young. When you're older it doesn't mean anything any more. Or when you are married a long time it changes completely, doesn't it?"

The therapist challenged her, "How do you mean, it changes completely?"

Mrs. B. answered, "When you are young it's kid stuff, . . . but when you get older you don't think about it; it doesn't mean anything. It's like a habit, . . . like brushing your teeth. (L) Your husband is there, and you're—and that's the way it is."

account by the patient, and by doing this stirred up motives in her to give a complete and correct account.

(K) "A younger man might be sexier?" the supervisor queried.

(L) *Patient describes sex as "a habit."* The patient here degraded the sex act to a mere act of hygiene, speaking of it as "a habit, like brushing your teeth." This is additional evidence of her frigidity. If the sex act can seem this way to her, it cannot have the reward in it that any person getting real satisfaction out of sexual activity would identify. Notice that the patient again blamed her

The therapist said, "I wonder whether that is the way it really has to be."

The patient replied, "I can't answer that question; I don't know."

The therapist continued, "Could it be that you would rather that it were not that way?"

The patient answered, "I don't know, I don't know any different. . . . It's a deeper feeling you have than when you're younger. It's a closer feeling when you get older. But in a different way. . . . It's more of a take-it-for-granted feeling; . . . you know he is there, that's all. . . . All I know is that it isn't the same as when you are young, but it isn't supposed to be, I don't think. . . . Bob is not a demonstrative person at all. . . . He doesn't call me pet names, . . . he doesn't show any affection, like some husbands show their wives. . . . He's never been that way. I guess I'm the aggressive one. . . . Nothing can be done. It's so foolish. I can't go out and get a divorce tomorrow just because I have a husband that likes to stay at home all the time."

The therapist said, "I think you sound disappointed."

Mrs. B. admitted, "Maybe I am disappointed; I have been disappointed all my life, . . . but then I feel guilty about talking about it, because I feel that Bob is good to me, that I shouldn't complain. . . . Maybe I expect too much. . . ." She said that maybe if they had lived by themselves when they were first married they would have lived differently. "Maybe it's because we were restrained when we were home. . . . Maybe Bob felt that he didn't want to do anything . . . or go out . . . on account of living at my mother's. . . . I keep thinking about that." (M)

The therapist inquired, "In the very beginning, when we first met,

husband, not herself ("He doesn't call me pet names, . . ."). See the discussion in paragraph (I).

(M) *Patient chose inhibitory circumstances.* This is an excellent example of how people may choose inhibitory circumstances and retain them. Probably it was not really necessary for them to live with her mother as long as they did. The choice of inhibitory circumstances was probably reinforced by escape from the anxiety which arose at the thought of leaving home and being alone with her husband.

you told me that in the years when you lived at your mother's house you felt . . . inhibited about intercourse. . . . If you had lived away, do you think that might have been different? Then you moved out of your mother's house, . . . did things change?"

Mrs. B. said, "I don't know. . . . Maybe that feeling stayed with us. Is it possible? . . . Maybe it got to a point where it didn't matter. . . . Maybe we felt that it wasn't important, because we had been restrained for so many years. . . . Maybe my husband felt that way. I don't know. . . . I felt relaxed and relieved when I was in my own home, because I felt free. . . . I still feel free in my own home, as far as that goes. . . . Maybe he's inhibited."

The therapist summed up, "This whole picture you painted of your married life and all the things you said about your husband, you said he's hard working, conscientious. . . . There has always been something missing, and this was your sexual relationship. . . . After all, when one has been married for a number of years one talks about one's relationship with one's husband. . . . There is the sexual relationship in addition to the other things. . . . I wondered why you have always been leaving this out. . . ." Perhaps "this is one of the things that you have always been getting away from."

Mrs. B. excused herself, saying, "I don't like to talk about personal problems, things like that."

The therapist continued, "That's what I meant when I said repeatedly that you would have to say some of those unpleasant things that we don't ordinarily talk about, because only when we have all areas of your life clearly before us can we understand what some of your problems are."

Mrs. B. objected, "I never liked to talk about things like that. . . . I always thought it was something that belonged to me."

The therapist chided her, "Then you . . . have been holding out, haven't you? And we can't possibly make any progress in the treatment."

Mrs. B. said, "I always felt that those things, nobody was supposed to talk about."

The therapist reminded her, "It's part of our general understanding that you will say whatever comes into your mind."

The patient still insisted, "I didn't realize that . . . I had to talk about those things too. . . . I still don't understand why they're so

important." (N) She greeted the end of the hour with the comment, "The time is up, and I still didn't get anything." She sighed.

TWELFTH INTERVIEW

The patient reported that she was going to Atlantic City for the weekend with a neighbor (a woman). She said she felt guilty about going and about all the money that it would cost, but she said, "I feel I'm entitled to it. I haven't been away in a long time."

Then Mrs. B. raised the question, "Maybe I'm not intelligent enough for psychiatric treatment. I can't straighten out my problems." She cried and complained and said, "It seems so hopeless."

The therapist said, "You must feel bad about something."

The patient replied, "Well, I spoke to my sister today. She ridiculed me for being so slow in treatment. She said my sense of reasoning was no good." The therapist pointed out that the patient seemed to be competing with her sister and reassured the patient that she would not have been accepted for treatment unless she were intelligent enough for it.

Mrs. B. began talking of her husband, "I've been acting awfully strange toward you . . . him, lately. He's kind. I don't know whether I've lost my love for him. He's more like a companion than a husband now. I don't feel that deep love feeling that I felt."

The therapist said, "If it were to change all of a sudden I'd be very much surprised." He pointed out that Mrs. B. seemed to be blaming the treatment because she was feeling bad, and he wondered whether this was really justified. He asked, "Isn't there something besides the money you'll spend that makes you guilty about the trip to Atlantic City?"

(N) *Therapist should relate patient's misery to the marital problem.* The supervisor advised the therapist to relate the patient's misery to the marital problem, thus to motivate the patient to go on, and at the same time to raise her hope, since a problem clearly seen is more often soluble. The patient can be motivated to talk on anxiety-provoking topics only if she clearly sees that talking about these is related to her fundamental difficulty and that the talking may eventually result in a decrease in her misery.

The patient said, "Is it that I'll have a good time? Maybe I feel that I don't deserve it."

The therapist pointed out, "Perhaps the thought that you'll meet other people, other men."

The patient denied that she would give in to any such temptation. She said, "There's too much at stake. There are my children and a reputation to uphold." Coming back to the question of why her feelings toward her husband had changed Mrs. B. said, "Maybe there's not enough feeling of warmth."

The therapist pointed out that any job is unsatisfactory when you don't get rewards for it. He said, "The reward in marriage lies partly in a satisfying sexual life with your husband."

The patient replied that she didn't feel that that was important. "It isn't that way when you get older. It's a matter of habit. It's like brushing your teeth in the morning."

The therapist challenged that, saying, "That I find very unusual."

The patient then blamed her husband for their unsatisfactory sexual life. "Maybe it's because my husband isn't romantic," she said. "I had plenty of opportunities, but I didn't take them; I was honorable."

She complained, "Bob is not demonstrative, he doesn't show any affection, so maybe we better keep it this way. I don't know how I can change. Maybe he doesn't satisfy me, maybe I need more. I don't blame myself for this; I blame Bob. He has never shown me any affection." (A)

The therapist pointed out, "Maybe you haven't done your part."

Mrs. B. replied, "He turns over and goes to sleep. So is it my fault? Anyhow I don't see how a good sexual life can make a difference in whether housework is a drudge." (B)

(A) *Patient again blames husband.* We have commented before on the patient's tendency to blame others, to blame the therapist, to blame her mother, to blame her husband, and so we shall not elaborate on it again. Nevertheless, she is showing more freedom in thinking and talking about sexual things.

(B) *Therapist advised not to change his strategy.* The therapist reported to the supervisor, "She spent most of the hour plying me

SUMMARY

The therapy got under way in the fifth and sixth interviews when the therapist insisted that Mrs. B.'s relationship with her husband must be important, that her resentment of her mother could not account for all her neurotic difficulties. In the eighth interview, he expressed disbelief that Mrs. B.'s mother could have "stolen" the children from her unless Mrs. B. had neglected or deserted them. Mrs. B.'s response to these interpretations was to admit that her married life was unsatisfactory and to blame this on quarrels over money, on her boredom with housework, and on the boredom with staying home in the evenings. The therapist replied that these reasons did not seem sufficient to account for her misery. Mrs. B. must be dissatisfied and frustrated in some important area of her life. Could it be that her sex life with her husband was not all that it ought to be?

Mrs. B. admitted obliquely that her sexual life was unsatisfactory by saying that when one is young, sex is rewarding, but "when you are married a long time it changes completely. . . . It's like a habit, like brushing your teeth." The therapist said, "I wonder if that is the way it has to be?" By this doubt he caused Mrs. B. to ask herself why her sex life should be "like a habit," and motivated her to try to discover what had produced this sad result.

with questions. I answered some of them and I did quite a lot of talking."

The supervisor advised, "You should not change your therapeutic plan because you are nearing the end of the treatment." (As previously stated, because of personal commitments the therapist was limited to ten weeks of therapy with this patient, at most. If she needed more treatment at the end of this period, she would be transferred to another therapist.) "Don't be anxious about your obligation to her. Do the best you can each hour but without any sense of pressure from the deadline on you. To react with a sense of pressure might result in an effect opposite to that you intend.

"She is getting you to talk so that she won't have to. Every time she succeeds in this the work is delayed."

The trend of the therapy in these hours was "from the outside to the inside." The therapist dealt with the sociological rationalizations that Mrs. B. offered as explanations for her misery. The quarrels over money, the boredom over housework, the boredom from staying home all had some plausibility as explanations of Mrs. B.'s misery, but they did not adequately account for it. By challenging their adequacy, the therapist bid for a better explanation. Without challenging these false explanations, the therapist could not advance the treatment.

THE CASE OF MRS. B.: The Patient Struggles with Sex-Fear Conflict

THIRTEENTH INTERVIEW

The patient expressed disappointment that her neighbor did not now plan to go to Atlantic City (as had been agreed) because her child was sick. Then she announced, "I lied last time. I'm not as honorable as I said I was." Mrs. B. said that she had had a number of affairs with men not her husband, but none within the past three years. She discussed these affairs evasively and in generalities. (A)

Comments at Supervisory Session

(A) *The patient's generalities conceal something.* The supervisor suggested that the patient's euphemistic talk covers up something. It is better that the patient use clear language. The therapist should ask for plain talk and should attack the resistance to communication. He should not just insist on getting certain facts, but should combat the resistance to communicating, which is based on the same force that produces the patient's frigidity.

The supervisor told the therapist, "By failing to interpret her resistance you failed to get the information you want—things that are perfectly conscious. It would be useful to know whether she was intensely aroused during these affairs. We had no good ground to suspect heretofore that she was capable of strong sexual responses.

"You should not solicit information about erotic episodes, but you should deal with her tendency not to tell you details about her sex

Then she said, "I had a terrible nightmare the other night. I woke up screaming. Bob told me later, 'You were complaining about the pain in your chest.'" Mrs. B. said she is still very resentful toward her husband and she believed that he was resentful toward her. She said, "We don't talk about anything at all. We don't talk at all about anything. I never talk about the treatment with him. Husbands get very suspicious of their wives when they go to a psychiatrist." (B)

Mrs. B. paused for quite a while. After the pause the therapist inquired, "What were you thinking about?"

The patient said, "I don't know why I came. Only to tell you that I lied to you about me being honorable. I feel I have said everything. There is nothing more I can tell you; I have told you all the bad things about me. You know there's nobody in this world that's really perfect."

The therapist comforted her, saying, "You were afraid to tell me this because you felt I might be angry at you? It is quite common for people to have had such experiences. . . . (C) As you say yourself, nobody is perfect."

Then the patient said, "When I was first married I was very happy and then nobody interested me."

affairs. You could have said here, 'I notice you talk only in generalities. That may be covering up important details. This shows you still have some fear of talking about sex.'

(B) *An example of transference.* This is an evidence of a transferred response. The patient has recently been talking about sex to the therapist. She knows her husband would be jealous if she had sex relations with the therapist. This fear generalizes to talking about sex with him, an act which in other circumstances often precedes sex acts. The patient has failed to discriminate the "safe" therapeutic situation from the one in ordinary life.

(C) *Therapist should avoid unnecessary reassurance.* The supervisor advised the therapist to avoid this kind of unnecessary reassurance. He advised instead trying to motivate the patient to go on and tell more by pointing out to her the role of fear in the vague way she is talking about these episodes. The therapist was reminded that, "Reassurance must be used to reduce fear so that new thoughts and acts can occur, and then to reward those new thoughts and actions."

The therapist asked, "And then what happened?"

The patient said, "It got very dull, my life became very monotonous. I guess I'm a bad girl at heart. I'm just a playgirl. I hate responsibility."

The therapist said, "Now you are calling yourself names and I don't think that explains anything."

The patient went on, "In my heart I would like to be a playgirl and not to be tied to anything. When I was young I wanted to run away from my house. When I was a little girl our home meant nothing. I was always glad to get away, it was so unpleasant all the time. Maybe I felt that way about hating to go home and the burden of it. I hated home then and I hate it now. You know I told you I hate housework and I always felt guilty about not doing housework. Couldn't it be a carry-over?"

The therapist said, "But your house now is very different from your home when you were a child." (D, E)

(D) *Generalities conceal useful data.* The supervisor advised the therapist not to talk at this time about the similarities and differences between the patient's childhood home and her present home, but to make basic interpretations of resistance that would push the treatment ahead. He said, "You are not likely to get far here, because you let her get away with a general account of her sex fears. She can't go on until she tells you more about that."

"Her reaction to your interpretation last week that something is lacking in her sexual life was, in effect, 'You are right; I went outside and got sex satisfaction.' Once you said it to her, she was able to think, 'If he feels I should get satisfaction somehow, maybe he would not disapprove of me for having got it outside.' I think that interpretation worked all right as evidenced by her ability to give you new information."

"But she can be pushed harder. Maybe in the beginning, when she said everything with her husband was lovely, we should have said, right then, 'That is hardly possible. Let's get out the facts that you really know about yourself.' Your interpretation was not premature, and I feel she has to tell you more about her affairs before you will be able to go back to the husband problem. When you see a resist-

Mrs. B. persisted, "Because I hated anything to do with the house then, I still hate it now. It sounds logical; even though it's my own I never want to stay home in it. Even though I feel it belongs to me I still don't like it." She continued, "I think it is the way I have been brought up. Home was never really a place to be happy in. Do you still feel that it has to do with my husband?"

The therapist replied that this might be one problem among others.

ance like that you can inquire. Her generalities are concealing useful data."

A correct theory of psychotherapy calls for interpretation of resistance. The therapist has to find out why the patient is afraid to talk and has to clear away these fears so that the interaction can proceed. The supervisor expressed his opinion that the patient was not telling all the truth, only a little piece of it. "There is a lot of insincerity. She is teasing you."

The supervisor indicated, "You may need that notion—that her habits are carried over from her parents' home—in another form. The reason that the patient is anxious with her husband is that there are real features of similarity between the past and present home. She learned in childhood that you don't do sexy things with the men you live with."

(E) *Therapist tries to teach discrimination between past and present.* The patient insists on a generalized account of why she hates her home. (Incidentally, one should notice that this is not mere boredom that she's talking about now.) She resists the therapist's attempt to teach her a discrimination between her childhood home and her present home. She tries to get his assent to the proposal that her trouble is a generalization to her own home from the childhood home, but she fails to see what is generalized—that is, that both sides of the sex conflict, not just the fear side, are generalized. Thus she avoids admitting that she has an unconscious conflict in connection with her husband. Furthermore, it is not completely clear why she hated her childhood home or why responsibility seemed noxious to her. It would, of course, take a genuine psychoanalysis to clarify all this.

(F) He then pointed out that the patient had said in the previous hour that in many ways her husband was like her father.

Mrs. B. agreed and cited examples, "Bob has a lot of those characteristics. He is kind and has a good disposition and he makes breakfast on Sunday mornings and he is so sweet to Doris and the boy and he is good natured with them and with me. He is like the rock of Gibraltar, some of the same characteristics my father had. Charitable, never turns anybody away. I guess I married my father."

The therapist inquired, "How do you mean?"

The patient said, "He is so much like my father I probably felt that way. He is so much older, but you can't love your father like you love your husband. You're not supposed to."

The therapist pointed out that one expects things from one's husband that one doesn't get from one's father. He said, "Could it be, for example, that the reason why sex is not important to you is that you find so much similarity between your husband and your father? Little girls are not supposed to love their fathers physically."

The patient agreed, "Maybe that is it." Then she asked, "How can I solve it? It is terrible. It's not fair, it's not fair for me to feel that way,

(F) *Therapist should take a stand.* The therapist should take a stand and should not cooperate with the patient's resistant views. The supervisor cautioned him, "You should take a stand. There I think you should have said, 'Yes, that's the way I see it now.' She should not have the right to choose lightly between your views. You had a chance to define her problem, to pin it down to the relationship between her and her husband and you let the opportunity go. When your interpretations are correct she will react by giving you convincing examples. The evidence for the validity of your interpretation would be that when you say it, it produces an effect—like a scientific hypothesis that predicts results in novel areas of fact.

"Actually she has reacted very well to your interpretations, but she is going to resist the idea that the trouble is in her own home, because that will put on her the burden of working it out. You don't need to avoid giving an opinion because it might be wrong, but of course you should not force your views on her."

is it? It's not fair to Bob. All these years I have been pretending that he has been my father in my subconscious mind; that is not fair at all."

The therapist said, "But now you understand he is your husband. There is a difference."

Mrs. B. replied, "But I can't change. How can I be different? I will still think he is my father. That feeling is still there; when I go to bed at night it is going to be hard to feel that Bob is my husband because it has gone on for too long, hasn't it?" (G) She continued, "Do you think that is why I used to do those terrible things I did before? I wanted adventure; I could not do it with my father."

The therapist agreed that that might well be.

Mrs. B. continued, "I just can't get over this, Doctor. Then I have a lot of making up to do, haven't I?"

The therapist asked, "How do you mean?"

Mrs. B. said, "I have so much to live down. I have cheated him for so many years, feeling not the way a wife should toward her husband."

(G) *Contemplating change produces fear.* The patient is willing to see the similarities but not to see the differences. She assumes that no change is possible. This assumption is reinforced by her escape from fear when contemplating making some change. To contemplate changing her behavior and being more sexually responsive toward her husband arouses anxiety in her, and saying to herself, "I can't do anything about it," reduces this anxiety.

The supervisor advised the therapist to explain the conflict to the patient exactly and plainly. He should make clear what is the same and what is different between her childhood home and her present home. What is the same is this: the feeling she has that "You cannot feel sexy about this man; you must feel guilty about feeling sexy with him, just as with your father." Feeling this way, the marriage situation seems to her like an incestuous situation; viewing the matter thus even the infidelities she reported would be preferable to the anxiety aroused in the incestuous situation. The infidelity is a symptom reinforced by escape from fear of incest as well as by the intrinsic sex rewards.

The therapist said, "You have also cheated yourself. You didn't do this intentionally." (H)

Mrs. B. asked, "What about Doris? Will she look for a man like her father?" (I) The therapist replied that this would not be unusual. Mrs. B. asked, "Could I have lost something completely, sexual excitement?"

The therapist asked, "Why should you have lost it?"

The patient said, "I don't know how to regrow it. Could it be dead between us? It doesn't seem as if I could ever be any different. You just can't change like that. I think physical attraction for Bob is completely dead, even though you brought to light my feeling; I don't see how I can ever be any different." The therapist pointed out that Mrs. B. had never talked about sex with her husband. The patient said, "Maybe it is because you don't discuss sex with your father. But what do you have to talk about? Is it necessary to discuss it? I think you don't discuss sex with your husband. We have never discussed it, never. As I said, you don't discuss sex with your father. I can't get over this, it is something like a bombshell. To think I have been living all these years with Bob and thinking he is my father"! (J, K)

(H) *Therapist should have let patient continue.* The therapist distracted attention by his remark, the supervisor maintained. The patient didn't need reassurance. The therapist should have been silent and allowed the patient to continue to work it out alone. He should have seen how far she could go by herself and what new things she would bring up.

(I) *Patient applies insight to a related problem.* Here the patient tried to apply the insight she had gained about her feelings toward her husband to the relationship between herself and her daughter. The fact is that the sight of her daughter reminded her that she has "sinned" and in this way aroused anxiety from which she escaped by turning the child over to the grandmother. But this, like many symptoms, had its consequences too—that is, it produced misery because the child, as a result, did not develop a strong affectionate relationship with Mrs. B.

(J) *What is similar is the inhibition.* The supervisor made the point that what is similar in the reactions to husband and to father

Mrs. B. asked whether she should tell her husband about what she had discussed in treatment. She said, "If he knew I was discussing him at all he would be furious, he would be mad to think I would talk about him to strangers. Is it normal to go back and tell your husband about these things? Is it something that most people do?" (L, M)

is the inhibition. "The absence of thrill is the result of inhibition. That is the way the little girl learns to behave toward her father. That is the greatest similarity between the two situations. Anyone that you treat in that way is in the parental role—for example, the priest, the minister, the doctor or the lawyer. The hallmark of the parental person is that he's the one you don't feel any sexual excitement toward. The patient is reporting this symptom but she does not recognize the reason for it.

"Another similarity between her response to her husband and her previous response toward her father is that one cannot talk sex with one's father. She does not do so with her husband."

(K) *Beware clichés.* The therapist should not have let pass the phrasing of the patient, "To think I've been living all these years with Bob and thinking he is my father." The therapist does not know for a fact that the taboo was implanted vis-à-vis the patient's father. All he knows is that she is inhibited and that the taboo was lodged in earlier times. The patient's statement reflects her reading of popular accounts of psychoanalytic theory. Still what she says is useful to her as a symbol of inhibition. It is not that she thinks that Bob is her father, but that she has the same limitations with him that she had with her father, the same feeling that there is nothing there for her sexually. The therapist should have directed attention to the patient's own conflict and not have let it rest on external similarities. The supervisor advised, "You want to label exactly what is similar because one falls into clichés too easily."

(L) *Goal is to change patient's behavior, not her speech.* The patient wants to change her speech but not her behavior. The supervisor recommended, "I think it is important for her to see the difference between merely talking and being an emotionally responsive wife. She wants to talk about her discovery rather than to become emotionally responsive. Her goal should not be to transmit to the

FOURTEENTH INTERVIEW

Mrs. B. reported, "It's hard to know what to do about that thought" (that is, the thought that she reacts toward her husband as she did toward her father). "I'm very confused."

The therapist told her that it was in just those areas where the husband was different from the father that the patient's insight ought to make a difference.

husband a piece of verbiage from therapy. The goal should be for her to be able to feel responsive to him and to talk about whatever appropriate subjects come up between them, including sexual things."

The supervisor said that the therapist might well say, "It is not usual to talk to anyone outside about what happens in therapy. Our goal is to enable you to behave better as a wife. What you do or say *after* you finish the treatment will be yours to decide."

The object of therapy is to change behavior. The patient should *show* the results of the therapy in her behavior. For her to give information that her husband could not understand might actually be destructive. By encouraging the patient to "talk sex" with her husband the supervisor did not mean saying, "The doctor said this" or "The doctor said that." The supervisor explained, "I mean loving gestures or erotic allusions, popping the question, 'Are you in the mood?' etc. But the first goal of treatment, even before talking, is to make the patient free to think about sexy things within her own mind when such thoughts naturally arise." The supervisor believed that the therapist might well have told the patient again that she has a serious sex conflict *within herself* and that the real object of the treatment is to help her to deal with it.

(M) *Therapist had and missed the opportunity to deepen the patient's understanding.* The supervisor expressed some incredulity because the patient's verbal reactions seemed too pat. Still, the reaction of the patient to all this was unmistakably genuine.

The supervisor commented, "I think you are getting a chance to deepen her understanding of her sex-fear conflict and everything

Mrs. B. replied that she didn't feel any differently toward Bob sexually. She recited a catalogue of complaints against him: "He doesn't notice anything. I can have a new dress, he never notices it. He never tells me that I look nice. I think a woman needs to be told that she is attractive to her husband. He isn't even affectionate to Doris and the boy. He takes me for granted. Like I said, it's like brushing your teeth in the morning." Mrs. B. reported, "Now that I see that my husband is not my father I don't have to ask him for permission to do things." (A)

related to it. She loves her husband but fears to show it. Her fear has been driving her away from him, from their children, from their house. Her attempts to escape through infidelity have been dangerous to them all. She must learn to turn and confront her fear. If she does, she may hope for a marriage and family life that will be far more bearable than it has been in the past. The solution proposed is approved by everyone. Why not put up to her the challenge to make something great out of her marriage? This has been quietly done by many conventional people. Why shouldn't a 'sinner' try?"

Compared with emotional understanding, the phrase "I married my father" is an empty cliché, as every specialist will recognize. What is real and active now is the fear that spoils her daily life with her husband. Knowledge of the past may help convince her of the reality of this fear and thus aid her to turn and confront; contrasting the past situation with the present may help convince her that no punishment awaits now as occurred formerly. Knowledge of the past may have still other functions, but if so they were not clear in this case.

(A) *Patient's attitude toward husband is childish.* The supervisor noted that the patient's revolt against her husband and her blaming him for any difficulties was a childish kind of reaction. It was as though she were saying, "Do I have to report everything I do to him?" The patient seems to have childlike aggressive reactions mixed into her marital attitudes. Her rebellion against her husband may testify to the early origin of these reactions. The patient is revolting against her husband's authority just as an adolescent might revolt against father or mother; and, as in former hours, she

Mrs. B. said that her husband's family was all mixed up, anyway. His brother had been in the state mental hospital and the rest of his family was nervous. (B)

The therapist referred to Mrs. B.'s part in improving the relations between herself and her husband. He said, "By your changing yourself you may be able to change the entire relationship between you and your husband." (C)

Mrs. B. retorted, "If you don't hear nice things from your husband that's probably why life is so dull and monotonous. So when I said to you I was dishonorable it was only for that one reason."

The therapist said, "You always use these phrases but you never say what really went on. I want you to be able to tell me exactly what you mean when you say, 'I was not honorable.' Call a spade a spade."

She said, "I don't like to talk about it."

neglects the possibility that she is inhibited, while emphasizing that her husband does not court her. It may be true that he does not, but neither she nor the therapist will ever know how inhibited her *husband* is until *she* is normally responsive.

(B) *Patient relates incest and insanity.* The supervisor remarked that there may be a roundabout reference here to a connection between the ideas of incestuous relations and going crazy. The latent idea may be that the husband also is guilty of incestuous acts and as such that he, or members of his family, might be "punished" by insanity.

(C) *Patient is in favorable situation for learning.* It is clear from the patient's account in this interview and the preceding ones that she and her husband have sex relations when her husband wants them. The patient views herself as a submissive accessory in the sex act. She does not enjoy it. The supervisor observed that her failure to enjoy and to participate is more likely to be a result of her own inhibition than of her husband's inadequacy. "The frigidity of this woman is taken far too casually both by herself and others. It is actually a serious illness."

The supervisor pointed out, however, that at least she is in a situation where she could learn if the therapist can reduce her fear enough so that she can try. This brings out the great advantage of

The therapist asked whether Mrs. B. was afraid to talk sex with him.

She insisted that she couldn't talk about it: "I'm sorry, I'm sorry I even mentioned it. I was just dishonorable, that's all." (D) The therapist insisted that no progress could be made unless Mrs. B. was frank. He pointed out that last time, after she had lied to him, when she finally got around to talking frankly they had made great progress. She replied, "Well, I was under the influence of liquor, I didn't care, I don't even remember except that I felt guilty next day. It was an outlet for me."

The therapist ended the hour urging Mrs. B. to overcome the fear of talking about sex. (E) He announced that the end of the treatment was not far off.

the person who is in a learning situation in contrast to a person who is not in a situation where he can learn—for example, the single person who does not have an easily available sex partner. Other things equal, therapy should be more successful with married persons.

(D) *Not following the rule expresses patient's revolt against authority.* The patient expressed insubordination toward the therapist by not telling him her thoughts, by not cooperating in the treatment, and by rebelling—in short, by not following the rule.

The supervisor had the feeling that she was not just afraid to say these things; she was defiant. Her hostility was transferred here. She regarded her husband and the therapist as authorities, like her parents, and she was in revolt against them.

Behind her façade there is a lot of competitiveness and masterfulness. "She wants to be the beloved child and yet be allowed to be naughty and not be punished for it," the supervisor commented.

Given more time, of course, Mrs. B. would have fully cooperated. In this case the therapist called attention to the rule, which he should have done, and Mrs. B. rebelled, which she had to do. She knew that the therapist would be available to her for only twenty interviews. One trouble with "deadline" therapy appears in this case where Mrs. B. knows that by holding out a few more days she will "escape."

(E) *Patient generalizes fear of talking sex.* It is plain here that the therapist mishandled the relationship. Part of Mrs. B.'s reluc-

FIFTEENTH INTERVIEW

The patient began the hour by saying in a depressed and complaining tone, "I am very depressed today. I don't know why, but I am. I have no ambition. Why should I feel this way?" She went on to say, "There are some things that I would like to talk about, that we didn't go into, about Doris. We didn't go into it at all really, and still those fears I have about sickness and death and things like that. We didn't go into this at all, and anticipation of things. I still fear sickness and I still fear death."

The therapist said, "What we want to do is what we have always done, follow the rule. I don't want you to put questions to me, because that is one way of getting away from speaking your thoughts."

The patient replied, "I did tell you about these fears before, but I still have them. (A) I have not been able to conquer my fears. Will I conquer them if I have a feeling of more security?"

The therapist replied, "It is a question of understanding much more than conquering."

The patient went on to say, "Doris wants to go swimming tomorrow and she has only been once, but I am nervous. There are my fears coming in again. The anticipation of something happening, of her

tance to give sexual information is based on fear. She has learned in the past that talking about sexual matters to a man may expose a woman to sexual overtures from that man. From her standpoint she is now in such a situation. She does not discriminate the safe professional situation of therapy from the ordinary life situation. In part, therefore, she is *afraid* to talk. The therapist should have explained this reluctance and had he done so he would have been "analyzing a resistant transference manifestation."

(A) *Statements in a new context are not repetitious.* This is not really repetition because when the patient brings up the idea a second time there are more parts of the pattern present than were previously available. The patient's statements may have a different effect because they are seen in a new light. The supervisor therefore advised telling the patient, "But now these things come up in a new

getting hurt. I get a nervous feeling inside. I want her to go. I don't want her to know that I am nervous about it, but I am. How can I overcome that, or is it possible?"

The therapist pointed out, "Again you are asking me a question which is what we don't want to do." (B)

Mrs. B. asked, "Is it because I blame myself because Doris gets hurt?"

The therapist countered, "Why should that be?"

The patient said, "It goes back to my mother again, that guilty feeling that I have had forever about Doris. I always feel that if I didn't do the right thing I would get the dickens from her. It's ridiculous."

The therapist reminded the patient, "We have discovered one important thing in this treatment, and I wonder whether we could use that to understand how you feel about Doris. The thing you have been feeling with your husband was like your feeling for your father."

Mrs. B. asked, "How would that go along with it? You mean that I have a fear of my husband? I don't think that is right at all, I don't think it has anything to do with my feeling for my husband. I think it goes beyond that; I think it has more to do with my mother than my husband. My mother has always put a fear in me about Doris. I tell you that she would never let me leave her alone."

context." This would give the patient a reason for discussing the problem over again. These matters come up under different headings, so one might say to the patient, "Don't worry about the fact that you said it before." This statement is, of course, what Freud advises (1943, p. 254).

(B) *Therapist should inquire, "Why are you asking so many questions?"* The supervisor told the therapist, "Don't just forbid questions. Rather, when a patient comes in with a barrage of questions you could say, 'Today you are asking me a lot of questions. Why?' Leave her with the problem of why the questions. They are forms of escape, obviously, so changing the resistant behavior may be crucial, but there may be some more basic question that she can't express behind the spoken ones. She may wonder, 'Do you love me? Will you forgive me if I attack you? Will you forgive me for hating Doris?'"

The therapist said, "We were wondering at the time whether you had some unconscious feeling that made you let your mother take over Doris's upbringing. We have never understood that and I wonder whether we could understand that better now that we have understood this relationship with your husband."

The patient said that she didn't understand where the husband came into the picture at all. "I didn't realize that I felt that way toward my father at the time—I mean to my husband." (Mrs. B.'s voice now sounded much livelier and lacked the depressed quality it had at the beginning of the hour.) After a pause she continued, "I never thought about Doris in this position. I still don't—I don't feel any different about Doris."

The therapist pressed the point, saying, "Feeling that your husband was in a way like your father, how would you feel toward a child from this marriage? How do you think you would have felt toward your children—the relationship between you and your husband being what it was in your mind?" (C)

Mrs. B. said she would probably be afraid of the children. "I would be afraid of my husband too because if anything went wrong I'm afraid he'd blame me for it. . . . I would be afraid to be disrespectful to him, and I would probably shield Doris more and not let her get any hurts. I'd protect the children more."

The therapist went on to say, "We had talked about the feeling that sexual relationships would be very bad if one were married to one's father. We were talking about how you would have felt about having children by a man who seemed like a father."

Mrs. B. replied with vehemence, "It would be terrible! It wouldn't be right."

(C) *Feeling toward husband accounts for rivalry with daughter.* The patient's feeling about her husband would explain her rivalry with Doris if she feels as though she and Doris are both the daughters and Doris is the younger daughter and the preferred one. Then one could see why she would feel rivalrous. In order to deny her incest "crime" she turns over her children to her mother. Then Doris becomes a rival and hence her wish for and fear of Doris's death and her fear of her own death. As the patient sees it, the punishment for

The therapist asked, "Then how would you feel toward the children?"

"Unwanted—that they didn't belong to me," she answered.

The therapist pushed her on, "Who would they belong to?"

"Their father and grandmother," Mrs. B. said.

The therapist asked if this would not partly also explain why she had let her mother take over, and Mrs. B. agreed, "Yes, that could be. Now that I realize it, yes. Oh, it's awful when I think back!" She paused. "Then I really had a right to feel like the maid, didn't I? I felt that the children didn't belong to me at all. Is that the reason why I feel the way I do now about them? It's silly now, when I think about it, now that I understand it."

Mrs. B. then changed the subject and began to criticize her husband for not being affectionate with the children. She said, "You know, my husband isn't understanding about the children at all. It makes me aggravated! But I don't blame him too much because that's the way he was brought up. But I feel he should be more understanding about them. Last night we talked a little bit, and I told him how I felt about his not showing the children enough affection, which I never thought I would be able to do, but I did. I'm getting so brave!" She chuckled with satisfaction.

The therapist said, "Yes."

"He has never shown Doris affection and it's terrible for a father to be that way," the patient went on.

The therapist gave a supportive, "umhum!"

"It isn't right! He said, 'Every time I go to put my arms around her

incest is death. In this way we could account in part for her depression and for her irrational fears about Doris. The point of bringing this out clearly is to contrast sharply the childhood learning situation with the reality of the present. The relation to her husband is not incestuous; Doris belongs to her, not to her mother; Doris is her own daughter, not her rival. If her rivalry with Doris is thus seen as stemming from a mistaken conception carried over from childhood, the patient can make the discrimination between past and present, and seeing how the present is different from the past need not carry past fears, abhorrences, and hatreds into present times.

she pushes away from me.' I said, 'The children aren't used to your going near them, and it is a strange feeling for you to come near them. Put your arm around them and maybe some day they'll want you to put your arm around them.' I don't know whether I was saying the right thing or not, but I think I was. I said to Bob, 'No matter how many times Doris pushes away from you, you still should put your arms around her, and then there will be a day when she will want you to.' (Mrs. B.'s voice had become aggressive sounding.) "I feel as though I was saying the right thing."

"I think it is a very good thing for you to be able to talk about these things with your husband," the therapist said. "I think that's a very good thing."

Mrs. B. continued, "I felt very good afterward. I think I had made a point! I don't know how at last I got it out—which I could never do before."

The therapist said approvingly, "I think that is very good!"

"So I made a point last night!" Mrs. B. laughed triumphantly. "I said, 'You were brought up the old-fashioned way. If you give people respect they will respect you.' He laughed at me, and I said, 'You ought to go to a psychiatrist,' and he walked away. I said I don't blame anybody for how they act because they can't help it, but he got mad, and I said he should go to a psychiatrist." Mrs. B. recalled, "I wanted to say, 'What about affection for me?' but I didn't. I was going to come out with it, but I only thought it." (D)

(D) *Therapist should not reward aggression against husband.* The patient tries to change her husband, not herself. The supervisor advised the therapist, "Don't reward her aggression toward her husband. The patient's defect has not been an inability to reproach her husband. I think that we should deal with everything related to her own problems rather than to how her husband reacts. So don't reward her aggression; don't reward her for arousing her husband's guilt about Doris while she dodges the application of this insight to herself."

"She was reproving her husband for not loving Doris and Paul. The next thought she had was, 'He doesn't love me,' but the truth is that she doesn't and can't love her husband. She knows that some-

Mrs. B. said that she felt as though she were a little more sure of herself since she had been coming to the treatment. "I feel I have a little more confidence in myself if I can come out and say things." She then discussed the problem of giving Doris sex information. "I feel this way: if anything does happen as she grows up I don't want to feel that it was my fault because I didn't tell her about the things she is supposed to know. I don't want to be blamed and have her say, 'Nobody ever told me about it,' but how can I do it? She ran away from me when I started talking about it."

Mrs. B. asked, "How will I ever be able to talk to Doris about sex,

thing is wrong with their relationship but can't decide who's to blame.

"She implied, by saying, 'You ought to go to a psychiatrist,' that her husband's life is not under his conscious control. This made him angry, because everyone prides himself on such control. People have a strongly learned motive to control their own lives, to be 'Captains of their souls'."

The therapist should not reward the patient for being childishly defiant to her husband. There is a popular theory that if aggression is suppressed one should express it, but the patient must be brought back to herself, brought back to considering how *she* can change. The therapist might ask her, "Have you set him an example with Doris?" The therapist should not defend her husband, but he ought to force the patient to see what she is doing. She seems to have the idea that one judges her progress by the amount she punishes her husband. The therapist could say, apropos of this, "Our measure of progress is how much you know about yourself and how much you can change your actions."

By rewarding the aggression, the therapist is wasting time. He is too active here and too much concerned with immediate detail, not enough concerned with the larger design of the problem. The patient's aggression comes from privation. The therapist therefore might well say, "The real issue may be that you can't love him. Not being able to love the one you're married to is very frustrating and it makes you hostile. You try to drive your husband away by aggressing against him. Of course, that's no real solution either."

because I have that guilt feeling? I know that kids know things. They must talk about it. Doris has a good book that I left in her room to read. I don't want her to be frightened about sex like I was, and I don't know whether my mother has told her anything about sex."

The therapist responded, "We have found that your ideas about sex were quite confused, and it may be a good thing that you have not transmitted them to her more than you have. If your view of sex was that a husband-wife relation was essentially a father-daughter relation, so that a woman should punish herself by handing her children over to somebody else, that is not what you would want to communicate to your daughter. The problem is not what to do with your daughter but how to straighten out your own thoughts. The best thing you can teach your daughter about sex is to show her an example of a happy wife with warm feelings toward her husband. There is nothing you can say to her in the face of a negative relationship. Children learn to love partly by seeing that their parents love each other. It is the emotional example that is important." (E)

Mrs. B. continued on the same line, "Some day I would like to talk to my mother and say, 'Have you ever told Doris anything about sex?' Maybe I will do it, but Doris is shy at this age. I didn't know anything about it; we never talked about sex. That is why I feel I am not close to Doris. I feel I have not been close enough."

(E) *The problem of giving sex instruction to Doris.* The supervisor told the therapist he had done well on the sex education point. He correctly said that the important thing is the emotional example that the parents set the child.

"A better relationship between Mrs. B. and Doris is the indispensable first step to furthering her sex education. The problem is not to get up a sex lecture but to have the relations between mother and daughter such that they can talk about 'dangerous things.' So the first step would be to have a much warmer relationship between the two. She will never be able to do a good job of sex instruction with her daughter unless they have a better relationship. A better relationship to the husband may be a precondition of this better relationship to Doris."

The therapist intervened, "But I think it is your feeling about your relationship with Doris that is important rather than the information about sex."

The patient said, "All these things I am worried about we have not gone into; you said I ought to think of things that are important."

The therapist said, "We want to talk about your own problems rather than how to give sex information."

Then Mrs. B. complained, "As far as sex goes, it is not cleared up at all and probably never will. And if it does I'll be surprised. I have made up my mind I would accept it the way it was. I have a defeatist attitude; I don't care. I could probably change myself, but I don't think I could ever change Bob as far as sex or romance goes. He doesn't know any better; he will never be any different. The other night I put my arms around him and gave him a big kiss, and he said, 'Is dinner ready yet?' and I said, 'The hell with it, there's no romance in Bob!' I tried, I made one attempt." Mrs. B. continued, "Maybe he doesn't love me; he never told me he does so I don't know. Maybe I have taken him for granted too much. Maybe I feel he did and maybe he doesn't. Maybe he has a lot of resentment about me inside that he is keeping to himself." (F, G)

(F) *Changing the relationship between patient and her husband.* The supervisor said, "The important thing is to change the relationship between herself and her husband. How can she do this? How do people know you love them? I suppose it's when you give them a break, are solicitous about their genuine needs, and don't make unreasonable demands. She should be able to *act* more lovingly toward him."

The therapist ought to keep the focus of the treatment on her and her conflicts and not worry about ancillary interventions that would leave the conflict unchanged.

It seems that the patient is struggling here to say, "Maybe I don't love him." Her fair-mindedness and struggle to solve the problem is the hopeful thing about her. She has ego strength. But she has taken a childish attitude toward her husband as though to say, "He should love me. He should make me sexy. I should be able to be petulant

SIXTEENTH INTERVIEW

The patient began the hour by saying she was confused about how Doris was tied in to her own relation to her husband. She afforded a good example of projection when she said, "You didn't want to talk about it and chose another topic instead." The therapist asked how the patient would feel toward her children if the children were the children of her father and she said, "I would have felt more like a sister than a mother."

The therapist said it was possible she felt like a sister toward them. Then he said, "How would this fit in to the feelings you report today? What would your attitude be toward Doris?"

She said, "I would not like the child, but I have always loved her." The therapist pointed out that while she may have loved Doris she might also have had other feelings toward her.

and he should accept it." The thing the patient doesn't think of is, "I should love. Do I love him, and if not, why not?" That failure to love is the most impoverishing thing in her life.

(G) *Therapist should not try to summarize.* The therapist asked, "Would there be any value in rehearsing with her some of the things she has learned?"

The supervisor's stand was, "I would go to the end by moving every step forward that I could. I would not make a synopsis. I think the important ideas will come back to her when motivation for them appears, even things she didn't seem to pay attention to here will come back to her. "Everything you have said which was true will be serviceable to her. So don't end up with a résumé.

"Therapy is like life. The day comes when you have to leave home or get married. The last day of therapy is just another day that you have to face and has the same kind of problems.

"Even if the patient leaves resenting the therapist, she has the big gift of knowing for the first time that she is unable to love. She attempts to compensate for that by being naughty (having affairs is better than 'incest'), rejecting her daughter, and so on. She has to build again the relationships with her husband and her daughter,

Mrs. B. said, "I was probably afraid I would do the wrong thing. I probably hated Doris because I was jealous of her and I was jealous of all the things that people did for her. . . . I would probably have resented the child and would have wanted to get away from her." The therapist inquired whether she might have felt guilty underneath, because on the one hand she was supposed to be the mother and on the other hand she was jealous and resented Doris.

Then Mrs. B. changed the topic and said, "People don't mean as much to me any more. I used to knock myself out trying to make people think I was gay and full of life, and now it doesn't matter to me any more."

The therapist drew the patient's attention to the notion that she felt guilty about the "incest" relationship and therefore had to put on a gay front before other people. He said, "This is an example of how you should be able to use our ideas in explaining the things you couldn't understand before." (A)

and that will take time. People know by repeated proofs in many different situations when you care about them. There is no substitute for these proofs, and she will have to do these things to convince them of her love. Only then, in turn, will they be able to reward her fully."

(A) *First label the conflict; then recur to its origin.* The supervisor was not very happy about this intervention. He felt that the therapist should stress the patient's current sex conflict rather than the origin of the conflict. In this case it might be better to emphasize that because of this conflict she draws back from the adult sex role, becomes childish, plays a "kid role" toward her husband, is rivalrous toward her daughter. The therapist, however, having been reading analytical books and misinterpreting some of the advice given, tended to talk to the patient about history rather than the details of her actual current behavior.

The ideal procedure in therapy would be first to establish the *fact* of the conflict; then to recur to its origin (for example, the incest taboo). One fears that the patient will remember only the slogan, "I love my husband as I loved my father," but forget that she is in conflict. Being able to recite the slogan in itself has little beneficial

Mrs. B. said, "Suddenly my husband invited me out to dinner, and that was so unusual I asked if he noticed any difference in me. He said, 'When I go away to Washington for the week end you don't make any fuss about it any more.' He said too, 'You're much better in bed, much more interested now.'" (B) The patient reported that she can do what she wants to now, "I don't have to ask my husband's permission any more." She asked the therapist, "Isn't that right?"

The therapist expressed the feeling that the patient had a habit of going to the extreme and that now she seemed to be revolting against her husband and being obnoxious toward him, as though he were her father. (C) The therapist reminded her of the difference between the husband-wife relationship and the relationship between daughter and father.

Mrs. B. said she felt one hundred per cent better. "I shall be grateful for the rest of my life. I can now talk to my mother about sex and I don't have to be afraid to ask my husband about money any more. I'm sorry I didn't come here earlier. . . . I feel I don't have to come any more. It is amazing how good I feel." (D)

effect, but being able to label her own feelings and behavior appropriately could have a great effect.

(B) *Patient reports change in real life.* This is a vital matter. The patient here gives a report of behavioral change. The patient gets well in real life, not in therapy, and it is encouraging to notice that the patient does report making a trial in real life of the things that she has mentally canvassed in the treatment. It is only in this way that she will get well. However, quoting her husband is less satisfactory than a direct report of changed feelings from her would be. Perhaps she is withholding this evidence out of orneriness. It is hard to see how her husband could notice a change without her being aware of it.

(C) *Therapist should label the conflict.* The therapist should direct attention to the conflict rather than saying, "In revolting, you're acting like a daughter toward a father." (See paragraph (A) above.)

(D) *Anxiety causes an attempt to escape treatment.* The supervisor remarked: "Coming from this gloomy patient these statements

The therapist pointed out, "There must have been things in forty years of life which you have not talked about. Maybe your reason for complimenting me is to get away from talking about something fearful."

Then Mrs. B. recurred to the problem of giving Doris sex instruction. She said, "Would you give me a book to read about sex instruction?"

The therapist answered, "I think it is much more important to think about your relationship to Doris. A healthy mother-daughter relationship is more important than your giving sex instruction." (E)

At the end of the hour Mrs. B. reported, "I still have this fear of death. I don't see how this can last, because I feel so good and things are so perfect. Things are just too good to be true now. I think this can't last. I have that feeling." The therapist asked her to answer this herself in terms of what she had learned. He wondered if she had some guilt about something she expected to be punished for. She said, "Fear of death too?" The therapist asked her to think about this. (F)

are surprising and seem to indicate progress. Yet, with the problem only partly solved, she seeks escape. After the first success she wants to get away since further anxiety looms as she contemplates further work. Escape is a symptom. One might call it therapeutic fatigue, analogous to 'Combat Fatigue' of the soldier." (She did, in fact, escape.)

(E) *Prerequisite to sex instruction is good relationship.* This point has been made before, the supervisor emphasized. One can't talk about sex with a person he dislikes and who dislikes him. Therefore, a prerequisite of the patient's discussing sex with her daughter is a better relationship between them.

(F) *Example of a homework assignment.* This is a good example of giving the patient homework. The therapist told the patient to think between the therapeutic sessions about why she might feel guilty. Often such homework assignments have gratifying results. The ideal result of therapy would be a skill in solving such problems for oneself. The patient should, therefore, have a chance to practice solving her own problems while still in therapy.

SEVENTEENTH INTERVIEW

This turned out to be the final hour of the treatment. Mrs. B. began by saying that her son had had a serious attack of asthma and had been sent home from his preparatory school. She went on to say that she was going to take him to a diagnostic clinic in Boston for a series of tests and so would have to break off her psychotherapy treatments. Actually the therapist had planned to discontinue his own work with this case after the twentieth session because he had to leave for Europe (on a Fulbright Fellowship) but the patient discontinued treatment at the end of this, the seventeenth session. Mrs. B. reported quarreling with her husband about money. She said she felt guilty over spending too much. (A) The therapist expressed his feeling that Mrs. B. equated money with affection and had always done this in the interviews. Then Mrs. B. told how her stepfather had blamed her for causing his divorce from her mother, and Mrs. B. said that she still feels guilty over this.

SUMMARY

In the eleventh interview the therapist challenged Mrs. B.'s rationalization that a socially unexciting life was the root of her discontent, and he confronted her with the notion that what she really was discontented about was her unsatisfactory sex life. Mrs. B. asserted that

(A) *Origin of the patient's guilt is childhood sex taboo.* After her euphoric report of the previous session, the patient is again in conflict. This kind of oscillation is to be expected. It indicates, as already said, that further work needs to be done.

The supervisor pointed out again that conflict about money is probably displaced from a sexual origin. He advised the therapist to conceive of the sex taboo in this way: "You should think of this as it might have seemed to a little girl. She might do some simple sexual thing such as masturbating or playing with a little boy or watching her parents with some sense of sexual excitement and just then she was smacked down; thereafter when she felt sexy she got a feeling of vague depression. It could express itself as boredom or bodily anes-

sexual desire changes when you get older, anyhow. The therapist told her that this change was not inevitable.

By the end of the eleventh hour the therapist had thus finished dealing with the main sociological rationalizations. Mrs. B. now admitted that her discontent was with her sex life. But she blamed it, first, on her mother and, second, on her husband. The therapist challenged these explanations and directed attention to the conflict within the patient. Responding to his interventions, she achieved a superficial understanding of this sex-fear conflict, saying she had believed her husband was her father. The therapist did not have a chance to enlarge and deepen her understanding of the conflict because the patient quit therapy on account of the acute illness of her son.

The next step in the therapy, if therapy had continued, would have been to work through all the implications of this sex-fear conflict. Mrs. B. would have had to label correctly both her sexual excitement and the fear evoked by the cues of her own sexual feelings. Each time she began to hide behind tiredness or preoccupation with her children as a way of avoiding sexual activity with her husband, she would have had to be able to tell herself, "Now I am avoiding thinking and acting as a sexually responsive wife because of fear." She would have to become more aware of the nature of her relationship to the therapist and have seen how fear was influencing it. She would have had to explore all the "ins" and "outs" of how fear affected her everyday behavior toward her husband and her children.

Not all of this would have to be done in therapy, of course, but

thesia." The supervisor advised the therapist to explain the sex taboo in some such simple terms to the patient.

"The examples that you provide," the supervisor pointed out, "serve as an invitation to the patient's memory. If your patient were the biggest sexual athlete in town you would have to be up and doing to convince him that fear was playing a role in his behavior. In this case, your patient has had quite a bit of sex experience and so you will have to give convincing examples that will be an invitation to her memory and will help her to remember and confess. Instead of deploring the lack of love and loving in her marriage, she shifts the accent to an analogous problem—money."

ideally, the analysis of the conflict should be carried much further than it was in the case of Mrs. B. We see, then, what the next steps of therapy would have to be. We can clearly see, too, that therapy in this case was incomplete. And we know what would have to be done to complete it.

FOLLOW-UP INFORMATION

One year after the treatment had been broken off, Mrs. B. was seen by her medical doctor. He did not have the psychodynamic information on the case and so could not make a detailed follow-up on the effectiveness of the psychotherapy. From the information which he reported to the psychotherapist, however, we conclude the following:

1. Though the door was open to Mrs. B. to return for further psychotherapy, she had not done so. This may mean that the therapy had reduced her misery so that she had felt no need for further treatment or that she had developed new and effective symptoms which had been partially reducing her neurotic suffering.

2. Mrs. B. was not depressed and did not show the agitation and distress that she had shown at the beginning of psychotherapeutic treatment. She described herself as "pretty happy now."

3. She made more or less conventional remarks about her family, especially her daughter, representing herself as reading up on adolescence so that she could understand her daughter.

4. She had been preoccupied with her son during the intervening year. (It will be remembered that she had broken off treatment after the seventeenth hour because the boy had severe asthma attacks and she planned to take him to Boston for special clinical tests.) She reported to her medical doctor in the later interview that the boy's illness had compelled her to be away from home a good deal. She had taken him for a stay in Arizona and was planning to take him away again because the change of climate might be beneficial. She had been up taking care of the boy frequently at night. (This behavior would enable her to escape from her home and her husband for considerable periods of time. It is possible that such escapes were reinforced by reduction of the sex-fear conflict with her husband. Knowing full well Mrs. B.'s capacity to evolve a cover story, we cannot estimate how much her preoccupation with her asthmatic son represented a necessary adjustment and how far it was prompted by a need to escape from her marriage.)

5. She did not mention her sexual relations with her husband so we cannot evaluate this aspect of her life. It might be that the psychotherapy had a real effect and that further experience had enabled her to improve her marital adjustment. It might also be that this problem was dropped at the point where she left it in therapy and that there was no further change.

6. In her interview with her medical doctor, Mrs. B. referred to the value of psychotherapy and her continued interest in psychological problems.

Whether words such as "success" or "cure" should be used in connection with this case we cannot say. Certainly many therapists would call a case like this "successful." We ourselves believe that the result justified the efforts that were put forth. We know that a process of interaction took place in the therapy, and this interaction may have made Mrs. B. aware of her own fear and conflict in regard to her sexual life. But this process, though well begun, was not completed. We cannot be wholly satisfied with the result of the therapy because we lack definite evidence that the therapy made it possible for Mrs. B. to begin getting those strong sex rewards that would vitally reduce her neurotic misery.

Whether psychotherapy is "completed" or not, however, a therapist should be held accountable for knowing where he was going and for understanding the dynamics of the case as far as it went. The real requirement of science is to know what the principles are so that you can follow the operation of these principles as far as you go. Whenever a patient leaves psychotherapy, the therapist should be able to say wherein the case had been moved ahead and where blocked; he should be able to make rough predictions about future behavior. If our report makes a contribution it will be because we knew what we were doing up to the point where the case was terminated.

STRATEGY :

Interactive Episodes in the Case of Mrs. B.

To have to bear the tension of unreduced sex drive is always a source of misery. This misery varies from a mild discomfort with slight sex drive to anguish with strong sex drive. If the sex drive is not only unreduced but is also a source of conflict—i.e., if the cues of sexual excitement arouse anxiety responses—the anguish is compounded. Neurotic people apparently suffer from this state of affairs.

The neurotic person is in conflict; in addition—and equally important—he does not identify his conflict. He cannot speak or think about it. He tends to avoid all reference to it. Because of the anxiety that rises within as the sentences describing his conflict begin to find utterance, competing sentences—not correctly labeling the conflict—are reinforced by reduction in anxiety. Thus the neurotic learns opinions that are in opposition to a correct account of the conflict. These incorrect statements we call *resistant opinions*.

In this chapter we examine a series of such resistant opinions—the ones that Mrs. B. expressed during psychotherapy. (These opinions are excited by the stimulus situation of “free association” which is, in effect, a bid to this patient to give a complete and logical account of her life.) The order in which these resistant opinions occurred is not a chance affair. The patient’s resistant acts and opinions are ordered in a hierarchy: the strongest habit appears first; when it has been inhibited, the second strongest appears; and so on through the hierarchy. Some responses may appear a second time, after having been inhibited temporarily. This is because the forces opposing this response

(e.g., drives to be logical) are again weaker than the anxiety that appears when the resistant response is blocked. Therefore a resistant response cannot be dealt with once and for all. It may recur one or more times after its first abandonment by the patient.

The same resistant responses would not occur in different patients in exactly the same order, since each patient has a unique history and a unique set of habits. For some patients, somatic rationalizations of their neurosis may be strongest; for others, blame of the sociological circumstances in which they find themselves may be the most strongly learned resistant habit. Which resistant acts and opinions are strongest, or which the patient has at all, depends on what he has learned under the peculiar conditions of his life history. It should not surprise us, however, that there is a good deal of similarity among the resistant responses of different patients. Similar circumstances in patients' lives lead to similar resistant habits. Although a patient's resistant responses cannot be forecast in advance of talking to a patient, one can predict with assurance that he is likely to have learned some resistant habits similar to those of other patients.

The period during which therapy is centered on a particular resistant act or opinion we call an *interactive episode*. The episode begins with the patient's resistant response. It continues as the therapist deals with the resistance. It ends when the patient abandons the resistant response. What follows is, therefore, a description of the interactive episodes in the case of Mrs. B.

Episodes are discussed not in the order in which the patient first presented the resistant response, but in the order in which the therapist dealt with the resistance and overcame it. The reason for this ordering is simple. An episode continues until the therapist effectively deals with a resistance. The patient may almost simultaneously assert several resistant opinions, but the therapist cannot deal with all of them at once. The therapist begins with the most obvious, "nearest" resistant opinion. Thus the therapy initially centers on this resistant response, and on the other resistant opinions only after this first one has been dealt with. For this reason it seems most sensible to present the episodes in the order in which the therapist effectively dealt with the resistant responses.

1. ATTEMPT TO CONCEAL THE TREATMENT FROM HER HUSBAND. Mrs. B.'s first resistant act was the proposal to conceal the treatment from

her husband. She said that she did not want to tell her husband because she was afraid he would forbid her to undertake psychotherapy. She said that she believed her husband would not let her have the money to pay for the treatment. She expected the therapist to cooperate in a deception, to agree to see her secretly.

This was really an immoral proposal. People who are intimately involved in the patient's life, as the husband is, must know that she is undertaking psychotherapy. If she had not told her husband about the treatment she could have said at any time, "I can't come because my husband might discover the secret."

The therapist, therefore, refused to accept Mrs. B. as a patient unless she would comply with the condition of telling her husband about the therapy. He told her (in the first interview): "It's important that this secret . . . should not exist between you and your husband. . . . Your husband should know. This is really one of the conditions for our working together."

2. **BLAMING THERAPY AND THERAPIST BECAUSE SHE FEELS WORSE.** In the fifth interview, Mrs. B. asserted, "I feel much worse than I did when I came here into the treatment." The therapist saw this as an attempt to discredit therapy and to manufacture an excuse for leaving. He replied, "I've had the feeling that you blamed me, and blamed the treatment for the way you feel." (Here he labeled the patient's blaming.) "This is unreasonable," he pointed out. "You felt bad when you first came here."

The therapist's action in calling the blame "unreasonable" aroused in Mrs. B. a drive to be reasonable and to give a rational explanation of her behavior.

Mrs. B. was facing the painful thoughts related to her conflict as she attempted the work of psychotherapy. The projection of blame for this pain onto the therapist would permit escape from this difficult, painful task. There was just a bit of truth underlying this blame: the therapist, indeed, did cause her to canvass her conflict, and this did tend to make her miserable. However, it was essential to deny her assertion that the therapist was "making her worse." It was necessary to oppose this notion by pointing out that her neurosis was the main source of her misery: "You felt bad—even depressed—when you came here. These problems are not coming up now for the first time; they've been with you a long time." Confronted with this evidence of the

illogic of her assertion, this patient, whose drives to be logical and reasonable were strong, abandoned blaming the therapist.

3. **NOTHING WRONG WITH HER MARRIAGE.** Mrs. B. asserted in her cover story that her trouble was in getting along with her mother and that nothing else was wrong. She refused to talk about her husband because "he's so sweet. . . . The only thing I'm worried about is my mother."

The therapist pointed out, in the fifth interview, that she had not said anything about her husband and had thereby left out an important area of her life. In pointing out this omission the therapist was noting a gap in the patient's account. For a patient who has strong motives to give a complete account, noting a gap in the account motivates him to fill it in. Mrs. B., however, was still prevented from doing this by the strong forces that opposed her talking about sexual matters.

When, in the eleventh interview, Mrs. B. again slid over her relationships to her husband (saying, "He was sweet. . . . Bob is very secure. . . . I always felt that Bob was the old reliable, . . . he was always there. . . . He still is . . . today."), the therapist challenged her assertion that all was well in her married life. He said, "You sound as if you were disappointed." By this intervention, he labeled the patient's emotional response; and by labeling the emotion as disappointment, he implied that something was wrong with the marriage. The question logically suggested by this was: "What's wrong?"

4. **GUILT ABOUT NOT DOING HOUSEWORK PROPERLY.** Mrs. B.'s report (in the sixth interview) that she felt guilty sometimes about not cleaning the house suggested a displacement of guilt, since the guilt was disproportionate. No woman ought to feel such a burden of guilt over failing to mop under the bed every day. Nor ought a woman feel guilty about going out with woman friends. But this was Mrs. B.'s claim.

The therapist therefore refused to understand her guilt. When Mrs. B. said she had a guilty conscience, he asked, "About what?"

Mrs. B. answered that she felt she really had no right to go out and enjoy herself; she should be home scrubbing floors or cooking. Even before Doris was born, she said, she felt guilty about her activities in the drama group.

The therapist still could not understand her guilt, and so asked her with whom she went out.

Mrs. B. answered, "There were a good many women in the group. I had many good friends in the group. And I would go out with them, or with some of the men. There were a good many men in the group. . . . But I even had the feeling when I was—before Doris was born—that I had no business enjoying myself." Then Mrs. B. turned the talk again to Doris and Paul and to the feeling she had that she ought to take the children to and from school and be at home when they came home from school. She complained that although Doris is now old enough to come home from school by herself and take care of herself after school, she (the patient) still feels guilty about going out and having a good time.

The therapist asked, "Are you worried about what other people might be thinking when you go out? . . . You say you feel guilty. Guilty about what? Before whom?"

Mrs. B. replied, "You mean guilty about my husband?" Then she added, "Yes, . . . Maybe I feel I shouldn't be enjoying myself."

It was not until the next interview—and after much exertion by the therapist—that Mrs. B. admitted she had gone out to a bar and drunk with some of the men in the drama group.

Because the therapist refused to understand Mrs. B.'s irrational guilt, the patient was led to bring out the true source of the guilt—her affairs with men in the drama group.

5. *ESCAPE FROM TREATMENT BY SOMATIC SYMPTOMS.* As Mrs. B. came upon topics that were laden with anxiety, she made moves to escape the therapy. Near the beginning of the seventh interview she complained, "I'm terribly nervous. My insides are making somersaults, I should have taken phenobarbital. I want to get home."

The therapist pointed out her motivation to escape the therapy: "Is it that you're anxious to get home—or is it more that you're anxious to get away from here?"

Mrs. B. answered, "No, I'm anxious to get to Doris. I'm not anxious to get away from here. . . . In the beginning I was, but not any more. I feel as though when I come here it is going to help. But I don't feel any different. . . . When can you tell whether I have improved or when can you tell I don't have to come any more?"

The therapist turned the question back to her: "Give yourself the answer."

"I feel as though I'm ready to quit," Mrs. B. responded. "I feel as though I have told you everything that has bothered me, and I'm ready to quit because I feel that nothing else can be said."

The therapist again labeled the patient's motivation to escape. "When you feel there is nothing more to say—as you do now—there must be something you want to say but find hard to utter," he pointed out. "You've come to something that looms up ahead and you feel peculiarly uncomfortable inside. Try to fight your reluctance to go ahead and try to say this thought that is about to come out."

By pointing out the escape from anxiety that was rewarding both the somatic symptoms and the belief that she had nothing more to say, the therapist enabled the patient to go on; and later in the same hour she confessed that she had visited bars with men friends from the dramatic group.

6. **BLAMING HER MOTHER FOR STEALING DORIS AND PAUL.** In the eighth interview, Mrs. B. complained that Doris "prefers her grandmother to me." Mrs. B. blamed this on her mother: "My mother practically took her away from me when she was a baby."

The therapist, challenging this explanation, said, "You said that your mother took Doris and Paul away from you. Couldn't it be that it was a matter of your letting her, rather than her doing it? That you *let* her take Doris away?"

The patient denied this: "No, I don't feel as though I let her do it. My mother never let me have Doris. She . . . she'd never give me the chance, really!"

The therapist insisted, "Couldn't it be that your mother's taking Doris away is a matter of your permitting it to happen?" He suggested that she may have been glad for her mother to assume the responsibilities of caring for the children.

In this interview the therapist—for the first time—challenged the patient's story that the grandmother had "stolen" the patient's children. Knowing that society strongly upholds a mother's right to rear her own children, the therapist was certain that Mrs. B. must have acquiesced to this "theft": she must have rejected or abandoned her children. He told Mrs. B. that she must have given over her children to her mother and indicated that she would thereby have been freed of onerous responsibility. The therapist's work in this hour transformed

Mrs. B.'s problem from "What can I do about my mother's stealing Doris and Paul?" to "Why did I give over the children to my mother's care?"

Because he knew that it is sociologically improbable that a grandmother could steal children from a mother, the therapist challenged the patient's story. By calling attention to the improbability of her story, he aroused her motives to have a reasonable and complete account, and thus he put the patient in the market for another, better explanation.

7. MONEY TROUBLES ARE THE CAUSE OF DISSATISFACTION IN HER MARRIAGE. In the sixth hour Mrs. B. first offered the explanation that quarrels over money accounted for her unhappy married life. The therapist refused to accept the money matters as sufficient cause for her discontent, reminding her that there are other things in marriage than money.

Again, in the eighth interview, Mrs. B. laid emphasis on quarrels about money. She blamed her husband for not giving her enough money. She felt she should be indulged more.

The patient continued on this theme in the next interview, reporting quarrels with her husband over money matters. The therapist responded, "Sometimes when people feel disappointed or cheated, they seize on something else as a bone of contention. Maybe your discontent is not really about money but about other things in your marriage that aren't going right."

This intervention of the therapist suggested the inadequacy of the financial explanation of the patient's quarrels with her husband and motivated her to find a better explanation. It also *labeled* her feeling of discontent—"You feel disappointed. . . ." Thereby it caused her to seek out the reason for her discontent.

8. BOREDOM WITH HOUSEWORK AND LACK OF SOCIAL EXCITEMENT AS SOURCES OF DISCONTENT. Although Mrs. B. did not altogether give up the notion that quarrels over money were the source of her difficulties with her husband, she did cast about for some other explanation of her troubles. The next rationalization she hit upon was that the drudgery of housework and the boredom of a socially unexciting life accounted for her misery. The therapist pointed out (in the tenth interview) that, although household tasks are somewhat unpleasant for anyone, most women can bear the unpleasantness because of the

other rewards in marriage. "But," he said, "when people feel they're not getting just rewards for their work, sometimes they get fed up. . . . Are you bored with your husband?"

What was the theory behind this intervention of the therapist? He knew that when a husband and wife have a strong sexual relationship, it spreads its benign effects to other areas of their lives. The petty, burdensome tasks of daily life can be borne partly because the husband or wife has a lively anticipation of sexual rewards. These anticipatory emotional responses bind together all the behavioral sequences of the day. They are a cement for marriage.

But if these anticipations are lacking, how dreary the unwelcome daily tasks become! As they did to Mrs. B., these tasks then seem an intolerable burden.

The therapist's intervention in the tenth hour did not dispose of this rationalization. Mrs. B. asserted that she was bored because her husband wanted to stay home rather than go out in the evening. He was quiet and reserved, a homebody, whereas she liked to go out and have a good time. Yet she felt she had no right to complain because her husband was reliable, hard-working, and good to her.

The therapist showed the inadequacy of Mrs. B.'s account by asking, "Are those really the only things you would expect of a husband?"

The patient replied, "No, I think a husband should . . . feel like I feel about having a good time. . . . What can I do? . . . I can't say, 'I'm going out to a nightclub tonight. . . . I want to have fun.' . . . It sounds stupid, doesn't it?"

The therapist said, "It doesn't sound stupid; it just sounds like an incomplete picture to me. . . . Isn't there something one expects from a husband that one doesn't expect from one's father?"

Mrs. B. got the point: "Romance? That is when you're young. When you're older it doesn't mean anything any more. . . . It's like a habit. It's like brushing your teeth."

Note that the therapist could not, by a single intervention, cause the patient to abandon the resistant opinion. He had to insist, firmly, that the uninteresting household chores, her socially unexciting life, and her husband's preference for staying at home could not alone account for Mrs. B.'s discontent. The therapist insisted that Mrs. B.'s account of her life was incomplete, and thus he aroused her motivation to have a complete account. Finally, he labeled the missing area

("Isn't there something one expects from a husband that one doesn't expect from one's father?"), and by pointing to the difference between husband and father began to teach the patient to discriminate between the two. His pointing in this direction should also have the effect of motivating the patient to give necessary information about her sexual life, which would fill a gap in her account of herself.

9. "SEX CHANGES WHEN YOU GET OLDER." When Mrs. B. abandoned the opinion that boredom with an unexciting life accounted for her misery, she substituted the notion that her sex life was unsatisfactory, but that this was only to be expected. "When you're older it doesn't mean anything any more," she asserted (in the eleventh interview). "When you're married a long time it changes completely, doesn't it? . . . It's like a habit, . . . like brushing your teeth. Your husband is there, and . . . that's the way it is."

The therapist dissented from this opinion: "I wonder whether that is the way it has to be."

We do not clearly understand why sex habits often weaken during marriage. But we certainly do not consent to the opinion that this state of affairs is inevitable, nor do we believe nothing can be done about it. With strong sex rewards and in the absence of fear, sexual habits should get stronger in marriage, not weaker. If Mrs. B.'s fear could be reduced and if the rewards she got from intercourse could be increased, her sexual habits within marriage should be strengthened.

The therapist's intervention challenged the inevitability of the lack of sexual rewards in Mrs. B.'s life. Mrs. B. accepted the proposition that the failure of the sexual part of her marriage was not inevitable. She did not, however, look within herself for the cause; instead, she blamed her mother and her husband.

10. *BLAMING HER MOTHER FOR THE FAILURE OF HER SEX LIFE IN MARRIAGE.* Mrs. B. blamed the lack of sex rewards in her marriage on the way her mother had reared her: "It's the way I was brought up; home was never a place to be happy in. When I was a little girl our home meant nothing. I was always glad to get away; it was so unpleasant all the time. Maybe that's why I hate it at home now. Couldn't it be a carry-over?"¹

The therapist answered, "But your house now is very different from your home when you were a child." Thus he challenged the patient's

¹ Quoted from the thirteenth interview.

too simple notion that her troubles in married life were a "carry-over" from childhood. What is the same in her childhood and in her marriage is her sexual inhibition. But Mrs. B. does not view this as a conflict within herself but as something to be accounted for by external events. What she has to learn is that the conflict is inside her; the sexual emotions are hers, the fear opposing these feelings is hers. She has to learn correct labels for the sex and fear emotions. And she has to learn that there is now no realistic basis for the fear attached to her sexual emotions.

She escapes the struggle of facing the conflict within by blaming her mother for wrong training and by calling her trouble a "carry-over."

11. **BLAMING HER HUSBAND FOR THE FAILURE OF THEIR SEX LIFE.** When the therapist failed to accept her carry-over theory, Mrs. B. looked to her current situation for an explanation of her trouble. But still she did not "look within." Instead she blamed her husband.

She voiced this blame of her husband in the twelfth interview: "Maybe he doesn't satisfy me. Maybe I need more. I don't blame myself for this; I blame Bob. He has never shown me any affection."

The therapist said, "Maybe you haven't done your part."

In the fourteenth hour Mrs. B. returned to blaming her husband. She said she felt no different toward him sexually than she had before discussing her sex life with the therapist. She complained, "I think a woman needs to be told she is attractive to her husband. . . . He isn't even affectionate to Doris. . . . He takes me for granted."

The therapist intervened, "By your changing yourself, you may be able to change the entire relationship between you and your husband."

This intervention did not make Mrs. B. completely abandon blaming her husband, for she returned to this theme in the fifteenth interview. "As far as sex goes," she reported, "it is not cleared up at all. . . . I have made up my mind I would accept it the way it was. . . . I could probably change myself, but I don't think I could ever change Bob, . . . so it's hopeless. . . . Maybe he doesn't love me; he never told me he does. . . . Maybe he has a lot of resentment against me."

The treatment came to an end before Mrs. B. was really convinced that there was anything *she* could do to make sexual relationships in marriage better. Therapy ended before she had closely examined the sex-fear conflict that was raging within herself. As we stated previously,

this unfinished business would supply a program for the next steps of therapy in this case.

THE TREND OF INTERACTIVE EPISODES.

The trend of the interactive episodes is from the outside to the inside; from sociological rationalizations of the patient's difficulty to formulations in terms of the patient's inner conflict. This trend proceeds step by step as the therapist, by crucial interventions, causes the patient to abandon resistant acts and opinions and to search for adequate explanations of his behavior.

The therapist points out the illogic and incompleteness of the patient's false explanations. He supplies better labels for the patient's emotions. He teaches discriminations between past and present. But—as he does these things—he is also doing something more. Through all of this, the therapist behaves as an emotionally intelligent person. He is perforce tolerant of the evil and error of the past. He values the patient's strengths and appreciates his struggles. He believes in the power of reason to master unruly emotion. He believes that everyone should have another chance to make a better job of his life. In short, the therapist tries to represent to the patient society's most enlightened attitudes.

The patient's search for more adequate explanations of his behavior and his acquisition of more enlightened attitudes go hand in hand. For example, Mrs. B.'s therapist, in challenging her belief that sex inevitably changes for the worse as married people get older, not only motivated her to seek a better explanation of her sexual difficulties but also said, in effect: "Society expects that you can have fun from sex. It's all right to get sexual rewards out of married life." Mrs. B.'s therapist here represented society's most enlightened attitude. A therapist's emotionally intelligent attitudes supply—in our opinion—the only foundation on which psychotherapy can be built.

TACTICS: Examples of Therapeutic Techniques in This Case

In order to give the reader a chance to follow the tactics of psychotherapy sentence by sentence, we present in this chapter a verbatim transcript of the eleventh interview from the case of Mrs. B. The comments made at the supervisory session have already been given in Chapter 5 and hence will not be repeated here. Instead, we have annotated the transcript to call attention to examples of the therapist's technique.

We considered presenting all or nearly all of the hours of this case verbatim, but decided not to because much of the dialogue is repetitious and dull in a typescript. Furthermore, movement during psychotherapy is necessarily rather slow. Obviously then it would be a waste of time for a reader to plod through complete transcripts of all seventeen hours of the case. Reading such a mass of detailed material would indeed tend to confuse and to distract attention from the main events. We decided, therefore, to present here only a single interview.

In this interview—the eleventh—the patient finally admitted that she had been “holding out,” leaving out of her communications any reference to her sex life. If the therapist in the early interviews had accepted her rationalizations as adequate explanations, Mrs. B. would never have stopped “holding out.”

Despite many excellencies of the therapist's work in this hour, there are faults in his technique. Other therapists might read this transcript with profit to see how domineering one can be even when trying not to be! The therapist was too active and so the interview has little

resemblance to free association. In fact, any other hour of this case would have illustrated free association better, although it would have illustrated other things less well.

Whatever faults there are in the therapist's technique, this interview excellently illustrates many techniques of therapeutic intervention: pointing out gaps and inconsistencies; arousing motives to have a complete and uncontradictory account; insistence on speaking whatever thoughts come to mind; bestirring of motivation to escape the misery of neurosis and to achieve the rewards of a better life; and labeling of unlabeled emotions. Because of the way it shows these techniques of intervention, this eleventh interview is most instructive.

The transcript follows:

The Eleventh Hour of Therapy¹

Patient:² . . . We've had a hectic day today. We've been working like slaves, my mother and I, all morning, since seven-thirty. For a big family dinner tonight. And I'm tired. But she's doing all the cooking. . . . I haven't that to worry about, but the little things, you know. Do you know I've been thinking about the conversation that we had last week . . . and . . . my life is very boring and dull . . . but it really is my own fault. I really should go out and get a job and work, I think, so that during the day my mind is occupied—my time is taken up at night—I'll be very contented to sit home and do nothing. And . . . and I guess I shouldn't complain about it . . . being so dull. Because it really is my fault.

Therapist: How do you mean, it's your fault?³

P. Well, I mean I shouldn't . . . I should be so busy during the day that at night I won't mind staying in and being bored or leading a quiet life. But . . . I don't know what I . . . I'm not qualified to do anything really—I mean to get a job. I used to take those parts in our theater group plays but I could never go into show business professionally. I could only work in a gift shop or as a receptionist or a telephone-answering service, or something like that. I haven't taken any courses in . . . in any secretarial work or anything like that. But I suppose I could do it. Now I could take up bookkeeping or typing and shorthand.

¹ This hour is discussed in Chapter 5.

² Note that the therapist lets the patient begin the session and choose the subject.

³ By not understanding, the therapist motivates the patient to explore further.

T. Yes, un huh.

P. I could get . . . you know, take that course and six easy lessons, is that what they—(*Laugh.*) you see it advertised. It's a short course. I was thinking about doing that. But, it's funny, I don't know what's the matter with me, I . . . is it that I have life too easy that I complain about it, or. . . I have two lovely children, I have a wonderful husband, I have a lovely home . . . but I'm not happy. That doesn't make sense.

T. I don't understand, you say is life too easy . . .⁴

P. Well, I mean is it because I . . . I have things too easy that I'm . . . I'm discontented . . . if I had it harder would I feel that I shouldn't complain about anything?

T. How does that sound to you?⁵

P. It seems logical. It seems that my life is too easy for me. That . . . I have no complaints to make at all for . . . I mean as far as . . . having a wonderful husband and a wonderful daughter and son and a lovely home, and I entertain when I want to . . . and it seems as though I'm discontented. I'm not happy and I complain all the time.⁶

T. Well, there must be some reason, don't you think?⁷

P. Well, I don't know, that's what I can't understand; why should I feel this way? Why should I feel that I'm discontented, that I'm looking for something all the time? Why shouldn't I be contented to stay home and . . . and have the things I have? I can . . . I don't know. I still can't understand it. Why should I complain about my boring life or monotonous life? I have no right to, really.

T. How's that?

P. Well, people . . . many people are worse off than I am, that haven't got the things that I have. Why should I complain? Why should I be unhappy? Does it have all to do with what I went through as a child?

T. Well, I don't see . . . of course other people have it more difficult and other people have greater problems—

P. Yes.

⁴ The therapist calls attention to inadequacy of the patient's explanation.

⁵ The therapist arouses the patient's drive to be logical.

⁶ The patient here is exemplifying the force and pain of unconscious conflict.

⁷ The therapist arouses the patient's drive to be logical.

T. —but I don't think we should judge your problem on the basis of what other people's problems are but should try to understand your problems and see why you should have . . .⁸

P. What am I looking for? I don't know what I want in life. What am I . . . what's . . . what . . . I don't know what is my aim in life. Shouldn't I be contented—the way it is? But I'm not. I'm unhappy.

T. Well, isn't that then our problem?

P. Yes, but . . .

T. Not the question whether you should or should not be contented, but the fact that you *are* not and that we want to find out why.⁹

P. But I'm ashamed to complain about it. Because I have so much. I mean I have a . . . a good husband and a nice house and a wonderful daughter and son. It really makes me ashamed. Am I making a mountain out of a molehill?

T. Well, there's something in this picture which seems to be missing; I mean you mention all these things that are seemingly satisfying and yet you are not satisfied—¹⁰

P. But I'm not.

T. —and there must be something that is wrong.

P. I don't know why—I can't put my finger on it, really. Well, I don't know what I'm striving for. What do I want? What do I expect from life? Why should I get bored all the time? Why should life be so monotonous? Is it because I don't have enough to do? Is it because I have time on my hands? If I went out and worked I probably wouldn't feel this way. I kept asking myself that for the past two days. I don't know what I want out of life, what I'm striving for, but I expect what I want . . . my husband is good to me, my daughter is wonderful, and I have a fine boy. I entertain nicely. People have said that they feel very welcome in . . . and I'm a cordial hostess, and they were comfortable in my home. Doesn't everybody do that? Isn't that everybody's life?

T. Well, if this were all so, then it would be very amazing that you

⁸ When a patient comes to therapy he does not realize what his real problem is. The therapist must therefore focus attention on the patient's crucial problem and pose it in such a way that it can be solved.

⁹ Thus the therapist is making the patient's task in therapy specific.

¹⁰ The therapist points to gaps in the patient's account.

shouldn't be satisfied. And I wonder whether these things really are so.¹¹

P. But, they are all so, but still I'm unhappy, still I'm unhappy, still I want to run away . . . and . . . and get away from my house. But I think it's lack of something to do, lack of interest, lack of . . . working maybe, that's what I need. Paul has gone away to school. Doris is growing up now, she doesn't need me for anything, really . . . except to get her meals and things like that, but that's nothing. And Paul is away at school all winter and at camp in the summer. My husband only needs me for the meals and things like that.

T. What kind of things? ¹²

P. Dinner, and washing and cleaning, but outside of that I . . . my time is my own.

T. Is that really the only thing that your husband needs you for?

P. Well . . . he's very . . . he seems to be very contented with the life that he lives . . . leads. I don't interfere with his life. He seems to . . . like to come home, and stay home and relax, after putting in a tough day with those law cases of his. I certainly can't . . . interfere with that. It wouldn't do me any good if I tried. We are . . . a . . . two very different personalities completely. He's very placid and reserved and I'm just the opposite. I'm happy-go-lu . . . I mean I used to be . . . happy-go-lucky and nothing bothered me too much. I like to have a good time. I like to have fun. I don't feel as though I'm old . . . too old to enjoy life. But he . . . he likes quiet things . . . the quiet life.

T. But this difference in personality hasn't been bothering you—at least you haven't said so—all through the last sixteen years or so.¹³

P. Oh, I thought about it . . . yes, I have. I've thought about it a long time . . . how we can be visiting and I'll be having a good time and all of a sudden he'll say, "Come on, let's go home." So, quick like

¹¹ The therapist doubts that the patient's account gives a sufficient explanation. This intervention is intended to motivate the patient to discover and adopt a better explanation.

¹² The therapist's question leads the patient toward the conflict area—anxiety in sexual relations.

¹³ Again the therapist's intervention challenges the adequacy of the patient's explanation.

that I have to leave and go home . . . I mean it's been going on for years. It isn't anything new. And as I told you before, if we're invited out and he's tired, we don't go. I mean things like that. But I guess I can't be a playgirl all the time. But I don't feel old . . . really, I mean, where I have to stay home all the time. I feel as though I want to have fun and enjoy myself. Is that wrong?

T. No. Of course, you are young; you are quite young enough to have an enjoyable life, and I think that you have a right to that kind of thing, but I'm just wondering . . .¹⁴

P. You mean it isn't wrong to still feel young in your heart and to want to get fun out of life.

T. If one considers such a thing as "right" or "wrong," I'm quite sure that that is not wrong.

P. Do I sound immature, do I sound like a child when I say things like that? Childish?

T. Do you think you do?

P. I'm afraid to say I do. I think it is childish just to want to have a good time and enjoy yourself. I think now that my children are growing up and I'm getting older I should want to settle down and not do anything—and just lead a very quiet simple life.

T. Why do you think you should?

P. Well, I don't know, I just feel as though I . . . I can't go out and do the things I used to do, although I still feel as though I could . . . I mean, inside. But it doesn't look right; it isn't right to do it.

T. With Doris getting older and more independent, do you feel that you are, well let us say, getting old, being an old woman now?¹⁵

P. No. It doesn't even bother me. I never think of it that way. Is that wrong?

T. No, what you say, that you feel that you should . . .

P. Well, I do . . . I mean, I feel I should on account of the people around me, convention's sake, you know what I mean, having people talk about me. I still feel that I can . . . I ought to have fun . . . and . . . and enjoy myself, even though the children are growing up and don't need me as much now. I think I really could

¹⁴ The therapist offers reassurance and agrees with the patient's rationalization of her problem, making a mistake in not pointing out specifically that the "right" she has is to use her marriage. He does say, "I was wondering," which hints that her rationalization was unconvincing.

¹⁵ The therapist tries to label the patient's rivalrous feelings toward Doris.

have a better time . . . but I'm afraid of what people will say. My friends, my husband.

T. What do you think they might say? ¹⁶

P. They'll say that she ought to grow up, she's not . . . she's got growing children, she should act like a mother. (*Embarrassed laugh.*) But Bob is very restrained . . . not restrained but placid; he's very quiet. We have been away—as a matter of fact I don't even enjoy going away with Bob, because he likes to go to a place where you can just eat, and sleep, and, you know, relax, go to bed early. I do that every night. All the time. I don't even like to go away on vacations with him, or anyplace . . . but I go. He wants to relax all the time; I'm not tired, I don't feel that kind of tired that . . . I want fun, I want life, I want . . . people around. Is that wrong?

T. Just . . . how do you feel about this? You seem to feel . . .

P. Well, I don't know . . . I can't understand . . . I mean, this . . . feeling that I've had about Bob being . . . placid. . . . I've always . . . held it in, I mean I've never said anything about it. I've never said, "Oh, I'd like to go someplace where it's fun." I've always kept my mouth shut and not said anything about it . . . because I knew it wouldn't do any good to say it. I mean it's always been in the back of my mind. We went away on a vacation once for four days, and all I did was sit on the porch and read. I can do that home. I . . . and people said, "Oh, you must have had a wonderful time on your vacation." I was bored to death! I hated every minute of it. Of course, I didn't say anything to him. I said it was very nice . . . but I hated it. And I won't go away with him any more. And I can't go alone, so I'm stuck. (*Half-laugh.*) So I . . . so I guess for me the only way I can go . . . I mean get away . . . is to go with him and do what he wants to do. So you see how different we are? Exact—just like night and day. Maybe it's better. Maybe he holds me down. Maybe I need that sort of thing. But I feel that I've missed so much in my younger days. I wasn't allowed to do anything. But I thought being married, and . . . it would be different. But it hasn't changed a bit. I mean as far as . . . pleasure . . . and enjoyment.

¹⁶ By this intervention the therapist rewards the patient for talking along these lines and encourages further discussion. He is also inviting the patient to say that she is afraid people will criticize her for getting into a situation where she might be tempted to have an affair with a man.

It sounds crazy, doesn't it? (*Pause.*) But he's so good that I can't . . . I guess I can't be any different with him, I mean I can't . . . I can't go . . . a . . . I can't disagree with him, as far as things like that go. I can't say, "I'm going out to a nightclub tonight and you can stay home." I've never done it.

T. At the time you were telling me about, when you used to be active in that amateur dramatic group and so on . . .

P. The rehearsals were sometimes in the afternoon.

T. Yes, but you were then also going out and having . . . fun. Did that have any relationship to this feeling? ¹⁷

P. Sure. It made me feel that I could have fun one or two afternoons or evenings a week, and I could sit home the other evenings. At least I had some fun; I got that in. But he . . . I . . . listen . . . I . . . I feel he's entitled to living the kind of life he wants to live. I don't object to it, I mean, as far as he's concerned. He puts in a hard day; he's tired. He really—I'd never deprive him of going to bed at nine o'clock or ten o'clock; I would never say anything to make him feel that . . . that I was unhappy about it, I just don't say anything. Course I feel terrible, but I don't say anything about it. We . . . we refuse a million invitations on account of him. Is it wrong to feel that you still want to have fun in life?

T. Well, there might be other compensations—

P. Well . . .

T. —for this, and I wonder whether you feel that there are or there are not . . . and, I mean, other compensations in your relationship. ¹⁸

P. Well, he . . . he's a . . . he's good.

T. How do you mean?

P. He's . . . reliable, he's honest, he's a hard worker . . . he's a homebody. (*Apologetic laugh.*) He likes to stay home. Maybe I haven't . . . maybe I'm not mature; maybe I'm still a child—I haven't matured enough, maybe I'm not grown up enough, I don't know.

T. Well now, the things you mentioned as . . . the good points of

¹⁷ The therapist here challenges the patient's "story" that she felt guilty about having "fun." He knows that she would not feel guilty about innocent pleasures. He believes that the guilt must be displaced and that its origin was probably guilt about having extra-marital affairs. So, the therapist reminds the patient that she had such affairs when with the dramatic group.

¹⁸ The therapist recognizes that the patient's failure to speak of the common and obvious matter of marital sex relations indicates that this is an area of conflict for her.

your husband. Are those really the only things you would expect from a husband? ¹⁹

P. No. I think a husband should be . . . as excited to do something as the wife should. I feel that . . . Bob should feel like I feel, about having a good time, about going out and being with people. That he should be as congenial as I am. (*Pause.*) Even when we were younger—I mean even before we were married and . . . we were engaged, it was the same way, although I always figured, well, he had a hard day the next day and I wouldn't interfere. I would let him . . . he would . . . we . . . when we used to have dates he left me at ten-thirty or eleven o'clock, early. We never stayed up past midnight, ever. I never remember staying out till twelve or one o'clock. I sound silly, though, to make an issue of it, don't I?

T. Well, this is a problem which is bothering you, and I don't see why you consider that silly.

P. Yes, but how . . . I . . . I can't straighten it out. How can I do anything about it? There's no way of . . . of changing it. I certainly couldn't say to Bob, "I'm going out on a date tonight, goodbye." (*Throaty laugh.*) Or, "I'm going out to have fun." I couldn't do that. I'm not built that way. As much as I would probably love to do it, I wouldn't do it. Is it . . . is it because I feel that I missed so much when I was younger that I feel that now I want to . . . do the things I didn't do before?

T. Is that what you think it is? ²⁰

P. Yes, I do. I think I never really had a chance to . . . really go out and . . . well, I don't know, it sounds silly to even talk about. It's ridiculous. Can't do anything about it anyway. I sound like a child. Once the pattern is made you have to stick to it, I guess. Once you start your life the way you do you can't change. Especially your married life. I've never told Bob how I felt about this . . . because I knew it wouldn't do any good. I'm sure it wouldn't. Because he wouldn't understand, he wouldn't . . . he . . . he'd think I was acting like a baby. So, if I get myself something to do during the day, where I'd get busy and not think about it, maybe it'll be better to . . .

¹⁹ The therapist continues to point toward her sex-anxiety conflict, which she seems to avoid discussing.

²⁰ The therapist does not want to take a stand on this matter and he wants to motivate the patient to talk more about it. He therefore makes a noncommittal inquiry.

- a . . . at night I'll be contented to stay home. It's like knocking your head against a stone wall, isn't it? Can you straighten out a problem like that? Is it possible?
- T. Well, I'm still not sure whether we really have the whole problem in front of us.
- P. Well, what do you mean? I don't understand; I've told you how I felt about it.
- T. But you say yourself, again and again, it sounds childish and it doesn't make sense.²¹
- P. But it's because there's no way of solving it. There's no way of solving that problem. How can I go to Bob and say, "I want to go out tonight. I want to have fun. I'm tired of staying home." If I did he'd say, "I'm sorry, I'm tired." So what am I going to do? Go out by myself? Can I do that?
- T. Well, that's a question you'd have to ask yourself.
- P. Well, I can't, I've never done it, I wouldn't know where to—how to start. So I keep asking myself, well am I str—what do I want out of life? What am I striving for, what am I working for? Where am I getting? I have a nice home, a nice daughter and son, a nice husband, but that's all. It sounds stupid, doesn't it?
- T. No, it doesn't sound stupid; it just sounds like an incomplete picture to me.²²
- P. Well, it isn't incomplete. That's exactly how I feel. I feel that I . . . do what I have to do, but I still want to get some pleasure out of life too. But why am I different from most people? Most people, I guess, don't feel the way I do. They don't complain about not going out. Well what's wrong with me? Why should I feel like I want to enjoy myself and have fun?
- T. Well, of course, again we can't say what happens to most people, because we are dealing with—appraising—your problem rather than other people . . .
- P. Well, that's what I mean, there's no comparison, I mean I don't understand it. There are . . . there's a friend of mine who . . . who's in worse circumstances than I am, but she never complains. Maybe because she has three kids to take care of during the day and

²¹ This intervention comes closest in this hour to the Rogerian technique of reflection (Rogers, 1951, pp. 26 ff.).

²² The therapist insistently points to the gap in the patient's account.

she's probably tickled to death when they go to bed so she can relax at night. Maybe it's because I don't have enough to do during the day. (*Pause.*) I don't know. But I've felt like this for a long time. I feel that I'm not getting everything out of life that I would like to.

T. What would you like to get out of life? That you're not . . .

P. I don't know. That's what I'd like to know. That's what I wonder. What do I want? What do I need? That's where I can't put my finger on it. There's something that I . . . that I . . . I'm hoping for, but I don't know what.

T. When you were engaged to your husband and this pattern had already been—you know you say this pattern had already been established back then—was there something that you were hoping for that might compensate you for some of the socially unexciting times? ²³

P. There was nothing. Nothing. I was young, I didn't know, I was madly in love. I thought he was wonderful and I adored him. I thought he was . . . a wonderful guy. I didn't look for anything else. He was sweet, he was . . . oh, I didn't need . . . I didn't want anything else. He was thoughtful and he was considerate. I used to work in a gift shop; I was substituting there one summer. He used to pick me up in the morning and drive me to work, pick me up at five-thirty in the afternoon. I thought he was just marvelous. And Bob is very secure. As far as I can see, he . . . he . . . nothing seems to bother him too much. And he's had a very tough life, too, because he worked his way through college . . . as a salesman . . . in the summertime. And his family were poor. He was really, he's really a terrific guy. Self made. (*Pause.*) And I always felt that Bob was the "old reliable," I mean somebody you could depend on all the time. That was the feeling I had, he was always there when you wanted him, when you needed him. He still is, I mean that's the way . . . you know. That's what he is today.

T. And yet, somehow you sound as if you were disappointed. . . .²⁴
I can't quite put my finger on it.

P. Disappointed? (*Pause.*) No, I don't know. Maybe it's because I . . . that he's older that I'm disappointed. I mean, maybe if I had married

²³ The therapist again directs the patient's attention to the sexual area designated, by her blocked associations, as her conflict area.

²⁴ The therapist labels the patient's unconscious emotion.

somebody younger that . . . that wasn't so . . . set in their ways. Bob is a lot like I remember my father to be. He had a wonderful disposition, easygoing, reliable, I mean, those are the traits.

T. Well, isn't there something that one expects from a husband that one doesn't expect from one's father?

P. Love and companionship? Romance? (*Pause.*) That's when you're young. When you're older it doesn't mean anything any more. Or when you're married a long time it changes completely, doesn't it? ²⁵

T. How do you mean, it changes completely? ²⁶

P. Well, I don't know, when you're young it's kid stuff I guess, but when you get older you don't . . . think about it, or . . . it doesn't mean anything. It's like . . . being married when you're older . . . it's like a habit. I mean it's like brushing your teeth. It's . . . it's . . . your husband is there and you're . . . and that's the way it is.

T. I wonder whether that is the way it really has to be. ²⁷

P. Well, I don't know. I mean I can't answer that question. I don't know.

T. Well, let me put it this way, could it be that you would rather that it were not that way?

P. Well, I don't know that either, because I don't under—I don't know. I don't know any different. It's . . . it's . . . it's a different kind, it's . . . a deeper feeling you have than when you're younger . . . I think. It's a closer feeling when you get older. But in a different way. I don't know, I can't answer that either, I guess. It's more of a take-it-for-granted feeling. Doesn't that make sense? I mean, does that sound . . . you know he's there. That's all. You know that he's . . . that you have somebody, that you . . . that you feel close to. I can't . . . explain it. All I know is that it isn't the same as when you're young. But, it isn't supposed to be, I don't think. People are not . . . Bob is not a demonstrative person at all.

T. How do you mean, "demonstrative"?

P. Well, I mean, he . . . he . . . he doesn't call me pet names, like some husbands call their wives or he doesn't show any affection, like some husbands show their wives . . . from what I've seen. He's

²⁵ This is a very common defensive belief, indicating that sex conflict is widespread among American people.

²⁶ By failing to understand, the therapist can arouse in the patient a drive to find a more adequate explanation.

²⁷ The therapist expresses doubts of the patient's account.

never been that way. I guess I'm the aggressive one. Oh, it's so silly to talk about this, because nothing can be done. It's so foolish. I can't go out and get a divorce tomorrow just because I have a husband that likes to stay home all the time. I can't do that.

T. What made you think of divorce?

P. Well . . . isn't that what people usually do when they're unhappy? Don't they usually . . . if they're not happy they . . . divorce? They . . . maybe . . . maybe I'm childish, thinking about it this way. Maybe I shouldn't even think about it. As my mother says, "You make your bed; you lie in it." I mean not that I've even discussed this with her at all, but I mean it's just that she's passed that . . . she has said that about . . . you know.

T. I wonder why you pick on this particular . . . saying.²⁸

P. What? "You make your bed; you lie in it?"

T. Yes.

P. I don't know, I've heard my mother say it.

T. Well, there are lots of other sayings. I wonder why you used this particular one.

P. Well, it's . . . it's something that you do, and you just have to . . . take it. (*Sigh.*) There's no way of getting out of it. Oh, I don't know, some days I feel like I just . . . like to go away and . . . just see what the other side of the world looks like. But I'm not—do I sound like I'm complaining?

T. Do you think you are?

P. I don't know, is it a complaint? Or is it just unhappiness or is unhappiness a complaint too?

T. I don't know. If you want to call it something, I think you sound disappointed.²⁹

P. Disappointed. Maybe I am disappointed. I've been disappointed all my life. It's nothing new. (*Pause.*) But then I feel guilty about talking about it. . . . Because I feel that Bob is good to me . . . that I shouldn't complain, or I shouldn't say it. . . . It sounds crazy. Maybe it's that I'm not matured enough. Maybe I'm still a child. Maybe I . . . I haven't grown up. Maybe I expect too much. I don't know.

²⁸ The therapist seizes on the use of the cliché to show her that she is reacting to the sexual side of her marriage and to ask her to talk about it.

²⁹ In this intervention the therapist supplies a label for the patient's emotion; the patient rehearses and adopts this label.

- T. What do you mean, expect too much?
- P. Maybe I expected more out of life.
- T. Such as what?
- P. Well, that's it, I don't know. I can't . . . I don't know. Everything isn't perfect. Sometimes I wonder if I had lived by myself, when I first got married, whether it would be any different.
- T. In which respect are you thinking of?
- P. I mean living by myself, alone, maybe our lives would be different?
- T. You say, how do you . . . I don't understand, you say by yourself alone?
- P. Yes, I mean living in a room by ourselves, without living in . . . in the house with my mother.
- T. Is it that "by myself alone" you mean "by ourselves"?
- P. No, I meant by ourselves alone. Maybe we would have lived differently, maybe we . . . I don't know.
- T. How would you have lived differently?
- P. Well, maybe it's because we were restrained when we were home. That we . . . that . . . maybe Bob felt that he didn't want to . . . do anything, I mean go out or anything on account of living at my mother's. I don't know, it's all . . . mixed up. But I keep thinking about that. Maybe our lives would have been different.
- T. In the very beginning when we first met, you told me that in the years when you lived at your mother's house you felt . . . kind of restrained, or inhibited about intercourse³⁰ because you had the feeling that your mother might be coming into the room. If you had lived away, do you think that might have been different?
- P. It might have been. Maybe it would have. I don't know. So many years ago, it might have been different.
- T. Well, but then you moved out of your mother's house, and that restriction or restraint, inhibition was removed. Did things change then?
- P. Yes and no.
- T. How do you mean?
- P. I don't know, I can't . . . I can't . . . I don't know. Maybe . . .

³⁰ After trying unsuccessfully to get the patient to talk about the obvious problem of sexual relations, the therapist mentions "intercourse." This intervention is not merely a request for information; it is permissive and should therefore tend to reduce the patient's fear of talking about sexual matters.

maybe, I don't know . . . I can under . . . I can't explain it. Maybe it . . . maybe that feeling stayed with us. (*Half-apologetic laugh.*) Is it possible?

T. Well. You have to tell me whether it did or not.

P. (*Laughing.*)³¹ Maybe it got to a point where it didn't matter. (*Cynical tone.*)

T. That what didn't matter?

P. Anything. That's not very clear, is it? (*Laughs.*)

T. No.

P. Well, maybe . . . maybe we felt that it wasn't important, because we had been restrained for so many years. Is that possible?

T. Well now, you say, "we felt," what did you feel?³²

P. Well, both of us. I'm sure. I don't know, maybe it wasn't me, maybe my husband felt that way, I don't know. I've never asked him.

T. Well, how did you feel about it?

P. Well, I felt relaxed and relieved when I was in my own home . . . because I felt free. Nothing bothered me. (*Pause.*) I still feel free in my own home, as far as that goes. Maybe it isn't my fault. (*Half-laughing.*)

T. What isn't your fault?

P. What you said.

T. What did I say?

P. Maybe . . . maybe he's inhibited.

T. You see, this whole picture you painted of your married life, and all the things you said about your husband, you said he's hardworking, he's conscientious, he's honest, and so forth. In all these things, there's always been something missing, and this was your sexual relationship and I always wondered why there was this hole, because after all, when one has been married for a number of years, one talks about one's relationship with one's husband. I mean there is the sexual relationship in addition to all the other things, and you have talked about all the other things and I wondered why you have always been leaving this out, and I wonder whether it's very difficult to talk about that and whether it may not be that this is one of the

³¹ The patient's laughter at various points during this hour is embarrassed and gives an implication of insincerity to her complaining remarks. Nevertheless she seems to be suffering.

³² The therapist asks the patient to label her emotional responses.

things that you have always been getting away from when we started talking . . . in this direction.

P. Well, I don't like to talk about personal problems, things like that.

T. But don't you know that, within the treatment, it's very important—

P. I know . . . but I still think it's none of anybody's business. (*Apologetic laugh.*)

T. —not to leave anything out. Well, as long as you feel that some parts of your life are none of my business, we can't get very far in our treatment.

P. I know. (*Pause.*) It's very difficult to talk about it because I never talked about it, with any—at all, ever.

T. I know, and that's what I meant when I said repeatedly that you have to work real hard in order to say some of these unpleasant things that we don't ordinarily talk about, because only when we have all areas of your life clearly before us can we understand what some of your problems are.

P. Um huh. I never liked to talk about things like that. I never have. I always thought it was something that belonged to me.

T. But then you again have been holding out, haven't you? ³³

P. Um huh.

T. And we can't possibly make any progress in the treatment . . .

P. I know it.

T. As long as you have this private understanding—

P. But I . . .

T. —that you will hold out on certain aspects.

P. To tell you the truth I didn't think it would enter the picture. I always thought that those things were never talked about. I didn't know you discuss things like that too.

T. Well, again, there shouldn't be anything that you think doesn't have any relationship, because whatever happens to come into your mind is what you want to say without any restrictions and . . .

P. Embarrassing!

T. Well, now it is difficult to say and it's embarrassing and it's sometimes frightening to say but nevertheless this is the hard work which

³³ The therapist's rebuke is necessarily severe here because he has to compel the patient to follow the free association precept, but the preferred line would be to examine what is keeping her from talking freely. Perhaps she is following an old pattern in feeling it dangerous to "talk sex" with a man not her husband and does not discriminate the therapist from a "natural man."

is involved in the treatment and you have to understand that there shouldn't be anything that you should keep to yourself, thinking that it has nothing to do with it or has nothing . . . is none of my business.

P. It's very embarrassing to talk about it. Because I always felt that those things, nobody was supposed to talk about. And I didn't know that I had to talk about them. I really didn't, honestly.

T. Well, it's part of our general understanding—

P. I know.

T. —that you will say anything that comes to your mind, do you see?

P. Yes, that's what you said. Well, I didn't realize that I had to . . .

T. That includes everything.

P. I didn't know I had to talk about those things too. (*Pause.*) The time is up. And I still didn't get anything. (*Sigh.*)

T. Well, maybe this is one of the reasons why we haven't gotten very far, because you still—³⁴

P. Because I've been holding out.

T. —have some private understanding that there are certain things that are none of my business.

P. I still don't understand why they're so important, I mean why things like that really . . . a . . . make a problem.

T. Because it's part of the general picture and in order to understand it we have to get at all parts of it.

P. Yes, that's what you said. See you on Monday.

³⁴ The therapist uses the patient's misery to motivate her to follow the rule of free association.

DYNAMICS OF CONFLICT: Illustrated by the "Spouse Phobia"

We have seen in Mrs. B. marked tendencies to escape from her home, her relationship with her husband, and her duty to her children. For example, she wanted to go out and be a party girl. She used her interest in the drama as a means of staying away from home evenings. She contemplated getting a job, just to be out of the house. These reactions are similar to the blind escape tendencies of the phobic person and we have ventured to believe that Mrs. B. had a kind of phobic reaction to her husband. We have called this the "spouse phobia."

Her fundamental conflict, as we have seen, was a sex-fear conflict focused on her relation with her husband. She was acting toward her husband as though he were a tabooed figure with whom she was not permitted to have sexual relations. It seems likely, though we cannot prove it, that this conflict was first learned in relation to her father and was merely generalized to her husband. We feel certain, at least, that the conflict was transferred from "somebody" to her husband because there was no evidence that it was learned in relation to him. As a result of her fear of sexual relations with her husband, Mrs. B. lacked the warm, positive feeling toward him that is ideally possible in the married state. She got little sexual satisfaction from her marriage. Therefore she was constantly under pressure from sex drive and, since sex appetites kicked up fear in her, she was constantly miserable.

Mrs. B. became depressed because she felt guilty about her sexual wishes and despaired of finding satisfaction as a wife. To have a beneficial and lasting effect on Mrs. B. the therapist would have to deal with the sex-fear conflict. In order to resolve the conflict, Mrs. B. would have to become aware that she was afraid, that the fear was transferred and irrational, and would have to start "practicing" rewarding sexual relationships with her husband in the light of this knowledge. Only when the conflict was replaced by a rewarding relationship to her husband would the phobia disappear.

Experience with other patients indicates that the spouse phobia may be a quite general problem among neurotic people; indeed in mild degrees it may be quite widespread in the general population. For example, one notices the typical married couple and wonders why the man should avoid his wife, hide behind the newspaper in the evening, go to bed before she does, arrange not to spend time with her alone, avoid "solo" vacations with her, or arrange to be with her only when other people are around. One also wonders why the wife protests fatigue, hides behind the children, gets an unnecessary job, or emphasizes distracting activities outside the home. Admittedly, these activities have rewards of their own in addition to providing a means for phobic escape from the spouse. It is fun to read the newspaper and to have other people around. It is rewarding to take care of the children and to be interested in things outside of the home. But we suspect nevertheless that these rewarding activities may get additional support from the fact that they are convenient and accepted excuses for escape from confronting the spouse.

One may properly wonder why a man should have fear attached most strongly just to sex activity with his wife, the person with whom he could with social acquiescence, if not wholehearted encouragement, have sexual gratification. One may reasonably wonder also why a man may say he is tired of his wife and seek affairs with other women when his wife is psychologically agreeable, personally attractive, and emotionally amiable. If a sex-fear conflict is at the bottom of such reactions how can it be that a man has less fear attached to a mistress or even a prostitute?

Viewing the matter from the standpoint of conflict theory seems to us to clear up many of these puzzling questions. Let us, for instance, apply conflict theory to the problem of why a man may have more

anxiety attached to loving a nice woman than to visiting a prostitute.¹ An unmarried patient, whom one of our student therapists was treating, seemed to be afraid of marital ties, but he reported going off on trips and sleeping with prostitutes.

In discussing the sex-anxiety conflict in this case, the supervisor pointed out to the student therapist that the prostitute may seem less similar to the tabooed women of the family than a nice girl does. The anxiety attached to sex has been learned in the family situation; therefore the more the woman seems like the family women who were tabooed as sex objects, the more anxiety the patient will have attached to sexual feelings toward her. Furthermore, the patient may have learned that he might be punished if he should make a woman pregnant. The prostitute is reassuring on this score. She is known to sleep with other men. No father, brother, or husband can make claims on her behalf. She evokes less learned fear because she is sharply differentiated from women of the family and from "nice girls" who also fall under family protection. This discrimination enables some men who could not otherwise enjoy sex relations to have intercourse with prostitutes. Even so, most men apparently have to reduce fear somewhat through drinking before they can approach a prostitute. When one sees that sex-fear conflict plays so large a role even in sexual intercourse with prostitutes it is not surprising that the same conflict plays a considerable role in relations with the "nice girl" to whom the man is married.

Conflict theory also throws light on the avoidance and escape tendencies that are so common among married people. Almost every married person shows some evidence of sex anxiety and some attempts to escape. The husband may not talk to his wife. Opportune quarrels may keep them at a distance from one another. He may insist upon having a distracting racket of radio or television programs when he is at home or may go out with the boys. We surmise that one of the things that tend to inhibit a man from talking with his wife is that if a man talks with a woman long enough eventually he will get around to sex—even with his wife! When the sex act is strongly op-

¹ Literature supplies an excellent example of this. James Boswell found it possible to have intercourse with streetwalkers but experienced marked fears when he contemplated intercourse with women who were more nearly "nice girls," such as Louisa and Miss Temple. See Pottle (1950, pp. 117, 273).

posed by anxiety, the anxiety will tend to become anticipatory and occur to speech or other gestures which are part of sexual foreplay. For this reason, an extra-marital affair may not indicate mere boredom or desire for novelty but actually the presence of fear in this marital relationship. If this should prove to be generally true, and if people could come generally to understand it, the knowledge might have a most benign effect upon the marriage institution generally.

Married pairs who can maintain a vital sexual life over many years are apparently few. Freud remarked ". . . habit binds a man more and more to the particular kind of wine that he drinks. But not to the woman he loves! . . . Why is the relation of the lover to his sexual object so very different?" (Freud, 1925, Vol. IV, p. 214.) Instead of marriage binding the pair closer, often the wife becomes a conditioned stimulus for anxiety which is added as an increment to the initial fear. Perhaps in these cases the sex rewards were never strong—because sexual responses are interfered with by fear—so that the basis for building strong sex habits is lacking.

When a husband gets "bored" with his wife and "seeks new experience"—i.e., begins to have affairs with other women—what can the wife do to renew his interest in her and interrupt his unfaithfulness? Traditionally, advice-to-the-lovelorn columnists advise the wife to make herself more attractive in order to win back his love. Under certain circumstances this is helpful advice, but conflict theory shows why this often does *not* work. For, if the wife makes herself more attractive sexually to her husband, she also increases his fear. His fear increases because, caught in the sex-fear conflict, he has strong fear attached to the cues of his own sexual excitement. The more sexually aroused he is, the more fear he has. If the husband's unfaithfulness is a result of his sex-fear conflict—if it really represents an escape from the anxiety produced when he attempts to act sexually toward his wife—the wife cannot get him back merely by making herself more attractive. Conflict theory indicates that her best chance of winning her husband would be to find a way to reduce the fear side of the sex-fear conflict. Perhaps this can only be done by having the husband undertake psychotherapy. Of course, if the fear reactions are weak enough to permit intercourse, sex excitement might drive him to his wife with good results.

When married partners are able to enjoy satisfaction in their sexual

life their ties to each other are strengthened by the sex rewards, and sexual anxiety will gradually extinguish.² Indeed this must sometimes occur because there are many people who, although they do not advertise it to the world, have a very rewarding sexual life together. But conditions that will permit this to happen are apparently not too frequent, since most people have learned so much anxiety in childhood and have such a strong sex-fear conflict.

Even when the spouse phobia does not drive a husband and wife out of marriage or cause them to seek extra-marital affairs, it takes away the rewards that are so necessary to making marriage a bearable and rewarding experience. Married life at its best contains many frustrations, many sacrifices, much hard work. If sex rewards are left out, if there is an insistent goading pressure of unreduced drive and a continual pressure of sex anxiety, then a great burden is put on the marriage relationship. But if the married partners can, despite their sex-fear conflict, achieve a satisfying sex life together, if sex rewards can thus appear as supplementary rewards in their daily life, then sex can be a powerful cement holding their marriage together. Without this cement, the marriage must be held together largely by pressure of conscience and social conformity. With the cementing reinforcement of sex rewards, husband and wife can be glad they are married. Certainly it would seem in the best interests of our society to have people achieve a satisfying sex life within marriage.

Society condemns sexuality outside of marriage but favors it in marriage. The habits rewarded in childhood, and especially in adolescence, are frequently ones which work against an active sexual life in marriage. Parents are pleased when their children do exceptionally well in school, when they engage in sports, when they develop talents, when they are ardent readers. Similarly parents taboo those activities which would, in a way, prepare their children for sex relations in marriage. To help adults discriminate permitted conditions for sexual activities from the tabooed ones, society has developed impressive marriage ceremonies. The minister, by his blessing of the marriage, gives to the married couple the community's permission to live together and have sexual intercourse. His words solemnizing their wedding are supposed to wipe out all the prohibitions on sexual relations that the society has

² Murdock (1949, p. 5) has discussed this point.

hitherto imposed on them. Unfortunately, the minister's words do not always have the desired effect. The bride and groom carry into marriage a residue of the inhibition learned in childhood and adolescence. Often the task of the psychotherapist is to complete the minister's job: to give married people the permission to be sexually responsive in marriage.

The conflict that prevented Mrs. B. from finding satisfactions in relationships with her husband is not unique. The spouse phobia occurs repeatedly in neurotic patients. Its repeated occurrence shows the fundamental character of the sex-fear conflict. The psychological mechanisms involved can be understood by the therapist in terms of conflict theory; and the therapist who understands will be in a position to help his patients get from their married lives the rewards they should find there.

Example of Spouse Phobia: Case of Mr. C.

There is perhaps no better way of showing how we can apply conflict theory to the analysis of these cases than to print two excerpts from a case, with comments on the dynamics. The spouse phobia is neatly exemplified in the case of Mr. C., a twenty-five-year-old married man.

We will present shortly excerpts from the tenth and thirty-sixth hours of his treatment. The excerpt from the tenth hour of therapy describes the childhood conditions under which Mr. C. learned strong fear of sex. He is punished by his mother and further threatened that his feared father will also retaliate. In learning the incest taboo he learned to avoid all women and to attach fear to his own sexual excitement.

The excerpt from the thirty-sixth hour shows the apparent effects from the earlier learning situation. When Mr. C. begins to feel sexually excited by his wife, he becomes annoyed and irritable. He wants to get up and punch the walls. He is afraid he will lose control of himself. (We recognize that such feelings are a sign of strong sex-fear conflict.) It seems to him that his wife is the one who is trapping him in this painful situation. Because he loves her he cannot get away from the dreadful conflict. He tells how he started to caress his wife, then stopped. Everything seemed distant to him. (At this point he was having an anxiety attack. He reacted to the anxiety with aggressive

wishes to break out of the trap. This is represented by his feeling that he would "do something that he had no control over.") It seemed an awfully long night.

Note that Mr. C. worked nights, while his wife worked in the daytime, and so they could seldom be together.³ This, it turned out, was not really necessary but was by his "choice." Note that Mr. C. in this way and by reading the paper or a sports magazine avoided his wife. Further on, the excerpt gives information from which we infer that Mr. C. avoided his wife on weekends. He said that he would like to be "carefree"—i.e., released from the terrible sex-fear conflict that he had in his marriage.

The student therapist interpreted the patient's aggression and his reluctance to accept responsibility but did not pin down the sex-fear conflict that was the root of the problem. This technical error is quite informative. It shows clearly that with an inadequate theory of the patient's behavior—a theory that aggression is at the bottom of his neurosis, a theory that neglects the frustration that produced this aggression—one cannot help the patient. The error is instructive, but this was small comfort to the patient who did not get the help he needed. Inexperienced therapists are likely to miss the fundamental point of a spouse phobia. It seems incredible to them that a husband could be afraid of sexual relations with his wife—the one situation where society permits sexual activity. But this is both possible and often true, and the sex-fear conflict must be dealt with in order to help such a patient.

The excerpts from the case of Mr. C. follow:

Excerpt from Tenth Hour of Therapy

Patient: From a kid up, I used to fear snakes, although when we were kids we used to catch them, put them in a jar, you know, and make them wriggle out. And I felt I don't—I don't like snakes or spiders; too clammy, as a matter of fact. I used to have dreams about snakes and—large snakes, real heavy ones about four inches in diameter and very large. I used to dream I was caught in between them, you know, a few years ago.⁴

³ The incident the patient described ("I was caressing my wife . . .") occurred on a weekend.

⁴ A psychoanalytic study of this dream, had the therapist been able to make it, would have been informative.

Therapist: How long ago did you dream this?

P. Well, a few years ago, I guess.

T. Was it before you went into the Service?

P. I think it was before—and during. When I was a kid I noticed I used to dream I was being chased. Particularly I remember being in my crib, you know, driving it like a car, and being chased by someone in another vehicle of some sort. And once in a while I used to dream I was falling. Then I'd wake up, sometimes, you know? When I was a young kid I walked in my sleep a few times.⁵ I was very young. My mother caught me one time. I was going near the open window, you know? I was very young, you know? I haven't walked in my sleep in twenty years, I suppose.

T. How old were you at that time—about five or six?

P. Yes, something like that.

T. Incidentally, who did you—did you sleep by yourself then?

P. Yes, I think so. Well, sometimes yes, sometimes no, you see? Ah, when we were very young, I had to sleep with my sister because we didn't have an extra room or anything for me. (*Laugh.*) I was thinking of a—I feel ashamed of it, but ah, I realize I was just a kid—ah, ah, playing monkeyshines with my sister, you know. I was just a little kid. I didn't know what I was doing. And my sister told my mother. My other sister told my mother. She used to sleep near our bed, and ah, my mother whaled the daylights out of me, you see?

T. Well, how old were you then?

P. Well, I was about twelve years old, I guess—thirteen—something like that.

T. Thirteen? And, at that time you were sleeping with your sister in the same bed? What do you mean by playing monkeyshines?

P. You know, diddling around—fingers—playing with each other. Stuff like that.

T. You mean you masturbated her and that she was masturbating you?

P. Well, at that time I didn't know what I was doing, I . . .⁶

⁵ The dream of being chased is apparently an expression of the boy's terror. The source of this terror may be threats of injury for masturbation or, as shortly becomes clear, for sexual doings with his sister.

⁶ Undoubtedly he was strongly sexually aroused by this sex play.

- T. Yes, I know. I was just interested in what you were doing. Sleeping in the same bed when you were quite young; that's very likely to happen.
- P. Children were just beginning to talk about that stuff. I suppose.
- T. So, how old—which sister is this?
- P. My younger sister.
- T. What are the ages of your sisters?
- P. Twenty-six and, ah, twenty-two.
- T. Twenty-six and twenty-two. Well, all three of you were sleeping in the bed?
- P. That's right.
- T. Your older sister would be about a year older than you.
- P. That's right.
- T. It was the younger one . . .
- P. That's right.
- T. And then when your mother found out about it she beat you?
- P. She explained to me what could happen, you see.
- T. What could happen?
- P. Well, she said that I—she'd be—she could become pregnant, you see. She said to me in the exact words—she said to me, the exact words, if I remember correctly, was: "Do you know your sister could have a baby from doing that?" I was amazed, you know, because at that time I didn't know just where children come from. I was really amazed.
- T. How did you feel about that?
- P. Well, I was frightened, I suppose.
- T. Your mother hit you. How did you feel about that?
- P. Oh, I didn't feel bad. I knew I had done wrong. She threatened to tell my father, and that hurt me worse (*Laugh.*) because, you know, he, he'd fly off the handle.

Excerpt from the Thirty-Sixth Hour of Therapy

- P. As I mentioned, that funny feeling built up in me last night. I was lying in bed and, I don't know, it seems that there was a feeling that I was going to lose control of myself⁷—I'd just get up and, and

⁷ The frustration from his sex-fear conflict evoked seemingly mysterious aggressive impulses.

punch the walls or something. I don't know what it was, and I started to think: "What could have caused it?" I guess I'd been worrying a lot lately; shouldn't work so hard—feel just burned out, run down, you know? Inside, I don't know, I feel as if I don't have the energy.

And yesterday I went over to the bank to see about a house, and they O.K.'d the mortgage, but I had to wait a half hour until he was ready, and I was very jittery, very nervous, you know? And I wanted to—while I was in there I, I was still very nervous, and I, I kept thinking that I, I was afraid that I was going to walk out, you know. And, then when I came home from work, I asked for my—I usually read the paper while I'm having a bite to eat,⁸ and then go to bed. I asked her if she had, had got the paper, and she hadn't, and I was a little bit peeved, you know—just a little though. And so anyway I ate and I went to bed. And there was nothing else to read, so I picked up a baseball book, and I guess this didn't help matters. There was a story in there about a baseball player who got hit in the head and went slightly queer over it. And I was half-finished with that, that story, and I felt I should go to sleep.

Meanwhile, while I was reading it, it was bothering me, you know. I was thinking of myself, I guess, you know, and I put it down and I put out the light and, and, then, I guess I got a little—ah—itchy or something, you know, so I started to—ah—caressing my wife, and, ah, she, she woke up, sort of, you know, and then I stopped and I laid back and after I laid there a while everything seemed to be like the feeling that comes when I lay down. Like everything seems distant, you know?⁹ It's hard to explain. I don't know whether you just realize the situation or you dislike it or what it is, but I,

⁸ This illustrates how a phobic man learns to avoid the sexual thoughts that might be stirred by talking with his wife. Reading the paper competes with and inhibits the sexy thoughts that might otherwise occur. Since the sexy thoughts produce anxiety, anything that inhibits the thoughts is reinforced by the reduction in anxiety consequent on their inhibition.

⁹ As he became sexually aroused, his own feelings of sexual arousal acted as cues for strong fear responses. Anything that could inhibit his sexual emotions would then be reinforced by reduction of fear. One can see how, under these conditions, the responses of stopping thinking and of drifting off into a state in which everything seemed distant could be strongly reinforced by a reduction in fear.

I felt as if that feeling came over me then, you know? And I, I don't know—I felt as if I was going to do something, that, that I had no control over, you see.

T. Did you feel as though you were going to hurt your wife?

P. Well, that was one of the thoughts, or the, the idea that I was just going to get up and—just start throwing things around the house, I guess. And I had a, well, it was like it used to be, you know.¹⁰ I had to get up and I, I got a cigarette, you know. I smoked a cigarette. I tried to, to get to sleep, and every time I thought of it, I—it was—I guess it stalled me, sort of, you know—that fear-building-up thing. And every time I thought of it, it would seem to go on, and be debating whether to build up again, you know? So finally I went to sleep, and it seemed like an awful long night. I guess I didn't sleep sound after that, and, when my wife got up at seven-thirty (I never wake up when she gets up) I woke up then, and I says, "What time is it?" She told me seven-thirty. I says, "Boy, it's a long night, you know?" So, I went back to sleep again.

At eight-thirty I woke up again, and the radio was playing downstairs, and they were talking sort of loud; looked at the clock, and it was eight-thirty and went back to sleep. Then I woke up in—about twenty after nine. I went back to sleep again. Each time I'd wake this, ah—the thought of that fear building up would come to mind. I, I'd seem to sort of force myself to go to sleep and forget it.

T. Exactly what is that fear like?

P. Well, the best way I can explain it, I guess, is that particular thought—I, I'm lying in bed and I don't know whether I sort of realize the situation just then or everything seems far away, you know. The place seems spacious, sort of and a, a feeling comes over me as, ah, I guess I want to get up, you know? And I'm just mad, I guess. I don't know why. I'm just mad at something, and I guess if anybody's around that the feeling comes to me, I just as soon start beating them, or beating the walls or something like that.

T. You say you realize the situation. What do you mean by that?

P. Well, I had been worrying a lot about the house, and that, that I

¹⁰ As we read the case, sexual frustration lies behind this aggression. He is afraid he may actually attack his wife, the person who makes him sexually aroused and therefore puts him in conflict. Note that the therapist tries to deal with the aggression without asking the essential question, "What is it that frustrates you, makes you miserable, and provokes this aggression?"

don't like living like that—my wife working days and me nights. I hardly ever see her. I just see her for a few minutes in the evening. And, and I was worrying about her, her having dreams, you know, so—dreaming. She talks in her sleep, sort of, you know?

T. Why should that make you worry?

P. Well, I don't know how this came about, but I seem to dread the thought that anything like this would happen to her. I don't know whether there's any grounds for thinking it but— And I love her, and I, I realize that it's more or less on purpose that I'm working nights so I won't be around her, and afraid of the fears building up inside, you know.¹¹ And I think of whether I should continue trying to get the house, you know, and if anything should happen that I can't work or anything—well, she couldn't handle it by herself, on the little salary she makes, and we'd lose what little we have got, you know? Last night I was worrying about work today, you know—how well—Actually I guess I was worrying how I'd be today, after that, you know? And we're supposed to go to New York on the week end, and I think of how it will be down there, you know.¹² And I'm worried that anything should happen, you know, and the fears that build up. And just suppose I—that, ah, that feeling that I have, you know, just actually happened. And then of course I have been worrying, as I mentioned before, about my family, with my uncle there, you know—wondering what was going to happen. I guess that everything generally didn't help, hunh? Then I had trouble with the car in the last two weeks. That cost me thirty dollars to fix. So—you work a whole week and put it into the car in no time.

I feel as if sometimes I, I just don't want to worry about anything—just be carefree. And then I feel, I feel that—well, it just isn't right, you know? You should give something, some thought, that you shouldn't just brush it off, you know? I guess I think of them too long though. That's being too tragic, maybe, but I feel I—if I shouldn't just brush them off—and then I feel as if I should so that they wouldn't bother me, you know?

¹¹ The patient knows that he is uncomfortable when near his wife, but he does not understand why.

¹² A week end in New York with his wife—with just the two of them, alone—would afford opportunities for sexual pleasure. For this neurotic man, such opportunities would result in increased sexual arousal, evocation of the fear that has been attached to his sexual feelings, and, as a result, conflict and increased misery.

T. It seems to me that a good deal of your resentment toward your wife and your current anxieties and fears over being very aggressive come from the fact that she's responsible—at least you see her as being responsible—for your not being carefree. You think because of her, for one thing, that you have to take this responsibility of purchasing a house, and you seem to resent that. Or, at least, it's causing you a good deal of concern, and you're worried about whether you're going to keep it or not. You probably blame her for putting you in that position.¹³

P. Can you—I wonder if you can do those things unconsciously and not be aware of it? Because I—I don't seem to be aware of that, you know? And that fear last night, now—

T. Well, just in terms of what you said—you said you wish you could be carefree. Now here you have all these cares and responsibilities.

P. Well, that's it. I mentioned that I, I wish to just be carefree and forget it all. And then again I feel as if I have a duty sort of there not to brush things off lightly, you know? That it requires some thought, you know. But I feel as if I've been thinking too heavily or too long; and too much of a tragedy, you know? I wondered last night, of course, when it happened, I, I thought: "What could cause it?" You know? And I thought of being—feeling run down and all. Right off, the thought, you know, and it's that, the thoughts toward my wife. Now what could cause that? It could be about the paper. It could be that when I tried that personal love that I was disappointed—could be. But I felt as if it hadn't bothered me. I wonder if it could do it—could bother me unconsciously, you know, without me being aware of it, you know? ¹⁴

Of course I also thought—I wondered if because that happened with all those fears returning, you know, the fears of everything I have, I guess—cemeteries and such and noise, and being crowded in the city. When I think of it I'm so afraid to go down to the city—fear that has built up, you know? And then I'm sort of afraid to stay here on the week ends—have a lot of time by myself, and I don't know what to do, you see, and it seems confused.

¹³ This is a clear example of aggression produced by sexual frustration; but the therapist made the error of ignoring the source of the frustration, Mr. C.'s sex-fear conflict which made his marriage a "trap" rather than a joy.

¹⁴ The patient hits on the source of his frustration: a sex conflict. The therapist misses it and is still following the "aggression" theme.

T. I think another reason why you might be very angry at your wife is that she's putting you in a situation where you constantly experience fear. That is, you still have a good deal of fear when you're around your wife. You're very uncomfortable—¹⁵

P. Un hunh.

T. And in that kind of a situation you probably feel very hostile toward her because she is making you feel so uncomfortable.

P. See what I can't understand is how you can love a person so much and then still—well—maybe be uncomfortable about them, you know?

T. Well, the very fact that you have so much love for her makes it difficult for you to admit to yourself that you have so much hostility toward her—or what the reasons for this hostility are.¹⁶

P. Inside I know it hurts me, you know, to think of that, you know—well—I love her so much, and that there are times I feel hostile toward her, you know? Seems closer till I, I feel as if it's a big kick in the pants—to think how well I was coming along, you know, and how I was feeling, and then to just have it build up like that. I guess it just didn't build up like that. It was a number of things that caused it.¹⁷

I was reading that story and, and I was wondering, you know, the, the—they put this fellow in a sanitarium, and he was there for a few years. Well, the people took care of him sort of, you know, and of course I thought, "Suppose anything did happen to me. Just what would happen later?" you know? "What would be the result?"¹⁸

One, one of the thoughts that come to mind is if anything like that should happen, if I would lose control of myself, I just wish that there would be someone around who could handle me, you know—who could keep me from doing any harm.¹⁹ And my main thought doesn't seem to be to accomplish that feeling, sort of, you know—if I did go berserk, sort of. Not to be able to accomplish it but to make

¹⁵ The therapist is finally approaching the spouse phobia problem—but only obliquely.

¹⁶ His comment is true but not helpful to the patient.

¹⁷ Sex frustration, of course, explains these aggressive feelings.

¹⁸ In the patient's mind the penalty for sex indulgence is insanity.

¹⁹ His fear is not only attached to the cues of sexual responses but also to the cues of aggressive responses. Thus he has two conflicts he must contend with. But if he could have been helped to solve the sex-fear conflict he might not have had to suffer with the aggression-fear reaction at all.

sure that someone's around to stop me from doing any harm, you know?

I also think that I simply can't let it get the better of me, you know? And I absolutely just can't. There's too many things that would foul up on me, you know? Er—Monday and Tuesday I had been feeling pretty good—very good, in fact. And just last night, just before this happened, I, I was with my wife. I think she was dreaming or something and, and she awoke, I told her, well (yesterday was her birthday, too, and I guess I was sorry I wasn't able to spend it with her and she had to go out and spend her birthday with people she knows from her job), I guess I felt it was my place to be with her, you know? Try to make her a little happy. I, I told her that, that I loved her and that I guess I would never forget how she's been sticking by me, you know, ever since I've been like this. I guess it wasn't—hasn't been easy for her, you know? Told her that it won't be long before we'll be getting straightened out, and then we'll have a house and our own furniture and some children, you know? Then when this happens, then you begin to wonder, you know?²⁰

Then I guess I thought inside that I just simply can't let it get the best of me, you know, and I gotta get out of it—fully out of it, not halfway or anything. And—because I really do want my own place and family, you know? And I guess I have been thinking about this draft business, you know—whether they'd call me or not and—oh, I suppose I'll have to tell them about this, and I guess they'll already think I'm wacky or something!

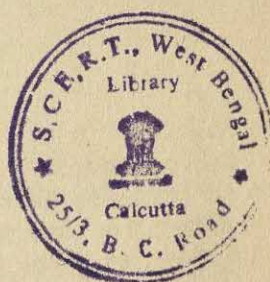
For this man neurosis is not a "disease" but a tragedy—a tragedy because all he wants is what society would like to have him have—a bearable marriage. The patient knows clearly enough what the goal is. The therapist, however, is misled by a wrong theory of the case and therefore cannot help him. With a correct theory of the spouse phobia, therapists can help Mr. C. and others like him to achieve the goal they so tragically missed.

The excerpt from the tenth hour apparently shows how the sex-fear conflict was learned, though we need not suppose this was the only training incident. What was learned, of course, was avoidance and fear of intercourse. In the thirty-sixth hour we see the result of sex

²⁰ This illustrates—pathetically—marital love stifled by fear.

inhibition on adult behavior. In bed and aroused by a familiar woman, the patient is inhibited, miserable, hostile, and fearful. Near his goal but unable to reach it, his conflict is intense. The pairing of these incidents in a psychotherapeutic case record drives home the fact that *all* sex training is training for—or against—marriage. It is for this reason that we must give close attention to our training practices in the sexual field. If the price of heedless or overstrict training in childhood is the weakening of the marriage institution, then we have a strong moral obligation to understand and, where necessary, to modify practices in the sex-training field.

PART II



THE PSYCHOLOGICAL TESTS TO BE USED

The first of the tests to be used is the Stanford-Binet Intelligence Scale. This test is designed to measure the general intelligence of individuals. It consists of a series of subtests which are administered in a specific order. The subtests are designed to measure various aspects of intelligence, such as verbal ability, non-verbal ability, and spatial ability. The results of the test are expressed in a score which is compared to the scores of other individuals of the same age. This test is one of the most widely used intelligence tests in the world.

The second test to be used is the Wechsler Adult Intelligence Scale (WAIS). This test is designed to measure the intelligence of adults. It consists of a series of subtests which are administered in a specific order. The subtests are designed to measure various aspects of intelligence, such as verbal ability, non-verbal ability, and spatial ability. The results of the test are expressed in a score which is compared to the scores of other individuals of the same age. This test is one of the most widely used intelligence tests in the world.

The third test to be used is the Terman-Merrill Intelligence Scale. This test is designed to measure the intelligence of individuals. It consists of a series of subtests which are administered in a specific order. The subtests are designed to measure various aspects of intelligence, such as verbal ability, non-verbal ability, and spatial ability. The results of the test are expressed in a score which is compared to the scores of other individuals of the same age. This test is one of the most widely used intelligence tests in the world.

The fourth test to be used is the Binet-Simon Intelligence Scale. This test is designed to measure the intelligence of individuals. It consists of a series of subtests which are administered in a specific order. The subtests are designed to measure various aspects of intelligence, such as verbal ability, non-verbal ability, and spatial ability. The results of the test are expressed in a score which is compared to the scores of other individuals of the same age. This test is one of the most widely used intelligence tests in the world.

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THE PSYCHOLOGICAL TESTS GIVEN TO MRS. B.

Immediately before her second interview with the therapist, Mrs. B. was given a battery of personality tests by a clinical psychologist. We were interested in finding out how useful these tests could be in predicting the patient's behavior in critical life situations and in forewarning the therapist about her typical personal reactions. After the testing the therapist listened to a sound recording of the session and he may have got some benefit from this. However, the handling of the case was chiefly guided by cues coming from the day-to-day reactions of the patient in therapy. Therefore, we feel that any correspondence between predictions made from the tests and the patient's behavior in the treatment is very unlikely to be accounted for by the therapist's knowledge about the testing session. We recognize, of course, that for a more rigorous evaluation of the tests the possibility that the therapy could be influenced by test results should be absolutely excluded.

The tests given were: the Thematic Apperception Test, the picture-arrangement test of the Wechsler-Bellevue Scale, the Rosenzweig picture-frustration test, a sentence-completion test, and a word-association test.

How Tests Were Chosen for This Case

The Thematic Apperception Test is supposed to give information about the strength of various types of learned and primary drives in the patient. The inventor of this test, Dr. Henry A. Murray, believes that

the themes of the stories told by the subject are related to the subject's personal needs, and that one can thus tell from the themes given what the subject's needs are. A knowledge of the patient's primary and learned drives, and how strong each of them is, would indeed be useful to a therapist. For this reason the Thematic Apperception Test was included in our test battery.

Our research interest in the picture-arrangement test stemmed from the notion that performance on this test might be an index of the subject's efficiency in thinking about social dilemmas. If the sets of pictures are samples of various kinds of social dilemmas, then the subject's skill in rearranging the pictures would partly depend on his ability to think and reason in these various areas, and his relative success on the different sets would be partly the result of his differential mental freedom (freedom from repression, appropriate labeling, etc.) in these different areas. It should be emphasized that this notion about the picture-arrangement test¹ is a hypothesis which should be tested and *not* a conclusion based on extensive evidence.

The reader may wonder why the picture-arrangement test was given alone without the other Wechsler-Bellevue subtests. It is not conventional to give a single subtest of the Wechsler-Bellevue Scale when making an evaluation of patients for therapy. We felt, however, that since the tests were being given as a research venture and not for routine diagnosis, there was no need to limit ourselves to a standard battery of tests or to the ordinary way of giving the tests. Without feeling under the obligation to give all the rest of the Wechsler-Bellevue Scale, therefore, we could satisfy our interest in finding out whether the picture-arrangement test does, indeed, show how skillful a subject is in thinking and reasoning about social dilemmas.

The Rosenzweig picture-frustration test was given because we felt that reactions to frustration were an important area of social behavior, and we felt that if the Rosenzweig test could give an accurate picture of the subject's behavior in reacting to frustrations, it would be an extremely useful technique. Like the picture-arrangement test of the Wechsler-Bellevue Scale, the Rosenzweig picture-frustration test presents visually a series of social dilemmas and it may show in some way how adequately the subject reacts in social dilemmas.

The sentence-completion test was included in our battery because of

¹ The notion is similar to a hypothesis put forward by Rapaport, Gill, and Schafer (1945, Vol. I, pp. 215-220).

reports from clinical psychologists of its usefulness in many situations.² A sentence-completion test should be superior to a questionnaire in so far as it gets more unguarded answers because of the requirement that the patient reply with the first words that come into his mind. To the list of incomplete sentences devised by Rotter, Rafferty, and Schachtitz (1949) we added a few to represent areas of learned drive that we felt were not likely to be well represented in Rotter's list. For example, we added a few incomplete sentences designed to elicit expressions about need for money and need for solitude. It was our intention, if the sentence-completion test should seem likely to be a useful technique, to scale each of the areas of learned drive and from the types of completions given in each of these areas to derive a score for each patient in each area.

Finally, we gave the word-association test because clinical experience indicates that "traumatic" stimulus words are likely to produce disturbance in the subject's response and thereby enable the psychologist to infer which areas of life are involved in the patient's conflicts.³ We utilized the word list prepared by Orbison and published in Rapaport, Gill, and Schafer (1946, Vol. 2, p. 84). We omitted from Orbison's list some of the more earthy words and added to his list words designed to represent areas of learned drive not adequately represented in the list as he had prepared it. For the word-association test, as for the sentence-completion test, we intended to make it possible to develop scales for each of the important areas of learned drive.

Other tests could equally well have been used, of course. For one thing, it is a matter of opinion what tests are best suited for personality diagnosis of psychotherapy patients, and there are no research studies on this point. Thus, we had to be guided by our own clinical experience and our own judgment as to what tests might be helpful. Furthermore, our study was not intended to answer the question of whether projective tests in general are valid for personality diagnosis but only to gather data on the validity of some tests we happened to be particularly interested in. The time for administering the tests was limited, and so we had to choose those tests in which we ourselves had the most confidence. For this reason we chose the T.A.T. and omitted the Rorschach. Other psychologists who think more highly of the Rorschach probably would have included it.

² Cf. Bell (1948, pp. 45-53).

³ Cf. Rapaport, Gill, and Schafer (1946, Vol. II, pp. 13-84).

The criticism may be made that the tests we used are of little value by themselves but might be useful when used in combination with other tests, for example, with the Rorschach. This contention is purely a matter of opinion. Statements to this effect have been made repeatedly in the literature on tests, but there are no studies giving any support to the opinion that a test having only slight validity when used by itself will have considerable validity when used in combination with another test. In this case, there is no reason to expect that *if* the T.A.T. is found to have slight validity it would have great validity when used in combination with the Rorschach. Indeed, mathematical analysis of the way in which individual tests contribute to the validity of a battery shows that (assuming linear combination of scores) a test does not contribute to the validity of a battery unless it is valid itself or is useful as a suppressor variable. Therefore if a test, say the T.A.T., failed to show validity alone, one would not expect it to be valid when combined with another test.

HOW TESTS COULD BE USEFUL

Personality tests would be useful to a therapist if they could do the following:

1. locate areas of conflict or repression;
2. determine the strength of the patient's various learned drives;
3. tell us the relative strength of his learned drives as compared to primary drives (since good adjustment depends on ability to delay satisfaction and to utilize learned rewards and learned motivations);
4. forecast the typical reactions of the patient in typical situations and their response strengths;
5. describe the patient's emotional responses to typical people in his life (e.g., to parent, brother, sister);
6. tell us whether the patient's emotional responses are correctly labeled and whether words and sentences evoke in him the expected responses;⁴
7. indicate whether the patient has the intellectual capacity necessary to learn in the therapeutic situation;
8. tell us whether the patient is in the habit of varying his responses

⁴ Failure to respond with appropriate emotions is one criterion of psychosis (Dollard, 1934, pp. 641-642).

until he hits on a solution to a problem or whether he bullheadedly persists in an ineffective response;

9. determine whether the patient was hopeful and felt that there was something he could do about his problem, or whether the patient was hopeless and felt there was nothing he himself could do about his problem, that it was up to someone else to set him right;

10. tell us whether the patient's learned drives to be logical and to have a sensible account of his own behavior were strong or weak;

11. bring out evidence as to whether the patient has had requisite types of social learning that are needed in therapy—for example, a well-developed conscience;

12. assess the over-all adequacy of the patient's mental processes, i.e., how well he is adapting to the realities of his life.

Implicit in all these possible uses of a test is the notion that it really pays off if it predicts how the individual responds in critical life situations. The therapist wants to know what the patient tested is going to be like in the treatment; what problems will arise and what conflicts must be dealt with. He wants to know what problems will come first. He wants to know which conflicts are strong and which are of minor importance. He does not care whether the test results correlate with the results of some other test. The payoff is real-life behavior in critical situations.

The tests given to Mrs. B. were analyzed by clinical psychologists not familiar with the case. A discussion of their interpretations will be given in Chapter 11.

For the reader who wants to check his own ability at predicting Mrs. B.'s behavior from the tests, we present in the pages that follow the essential personal data needed to interpret the tests and then the patient's test responses, as transcribed from a sound recording.

PERSONAL DATA ON MRS. B.

The following personal data are considered by Murray (1943, p. 6) to be necessary for interpretation of the Thematic Apperception Test:

1. *Sex and age of the subject:* Female, age forty.
2. *Whether his parents are dead or separated:* Patient's father is dead; her mother is living.

3. *Ages and sexes of siblings*: Patient has two siblings—older sisters who are living.

4. *Vocation*: Housewife.

5. *Marital status*: Married, has two children—a boy twelve years old and a girl fourteen years old.

Transcript of Thematic Apperception Test ⁵

Examiner: Now you'll find that this is not so bad.

Patient: What is it, just answering questions?

E. The first test here is a test of imagination, one form of intelligence.

P. Um humm.

E. I'm going to show you some pictures, one at a time.

P. Um humm.

E. And I want you to tell me a story about each one. Tell me what has led up to the event shown in the picture. Describe what is happening at the moment, what the characters are feeling and thinking, and then give the outcome. Speak your thoughts as they come to your mind. Understand how it goes? You have about thirty minutes for ten pictures, so spend about three minutes on each picture. Here's the first one.⁶

(Picture 1.)

P. Is the three minutes up? I mean do I have to wait the three minutes?

E. No. I said you have about three minutes to tell me a story about each one.

P. Oh, I see. Well, I think this little boy is probably very unhappy about the violin. He probably is forced to take the lessons and he probably is very disinterested in it. And he probably won't grow up playing the violin at all. Is there anything else? Did I answer all those . . .

E. Well, I wanted you to make a complete story, so I told you to tell me what had happened before we got to it, what was happening, what he was thinking and feeling, and how it came out.

P. I imagine his mother and father wanted him to become a musician and to play the violin, but he's a very unhappy looking boy and I

⁵ Cf. Murray (1943); Morgan and Murray (1938); and Morgan and Murray (1935).

⁶ These instructions are adapted from H. A. Murray, *Thematic Apperception Test Manual*, p. 3. Copyright 1943 by the President and Fellows of Harvard College.

think he probably has no feeling for it, whatsoever. And he's just looking at it, and in a very unhappy way, and he probably will never be able to play it because he doesn't like it.

(Picture 2.)

E. O.K., that's fine. Here's the next picture. Tell me a story about it.

P. What is this supposed to be? A. . . .

E. Well, it could be anything you'd want to make it for the purpose of the story.

P. Well, this looks like this girl . . . with what . . . has to go to school and her . . . she'd be much happier staying home and . . . plowing with her father—if that's her father. And her mother looks as though she . . . won't think of it at all, won't let her stay home because she wants her to have an education. And—the girl looks very unhappy about the whole situation. And that's all I can tell you.

E. How does it come out? What do you think about the end?

P. Well, she probably is forced to go through with her education and probably ends up as a schoolteacher.

(Picture 3GF.)

E. This is the next one.

P. Well, this person looks as though there is either sickness or death and she . . . a . . . can't face the situation. She's emotionally upset. And . . . well, it's hard to say what this one really . . . whether it's sickness or death or whether she was thrown out of her house, or . . . it's . . . but . . . I imagine everything will turn out . . . time's a great healer, she'll probably be all right . . . after things get straightened out again.

(Picture 4.)

P. This woman . . . this man . . . this is . . . this woman is . . . the man's wife. And he . . . is probably having . . . some flirtatious affair . . . if that picture in the background means anything. I don't know. I mean of this one. And . . . his wife is trying to keep him from go—leaving her, to go to the other woman, and . . . he isn't even listening to her, he has this other woman on his mind. And eventually, he leaves her. I don't know how my imagination sounds. I don't—ridiculous, I think . . .

(Picture 5.)

E. All right, how about that one?

P. This woman is coming into an empty house. Her husband dies, and

she's a little frightened . . . coming into the room, where it used to be so gay and happy, and she's hesitant about walking in, but she has to, because that's the way it goes.

E. How might it come out?

P. Well, she just has to . . . a . . . she just has to live, life goes on, and she just has to make up her mind that she's going . . . into the world.

(Picture 6GF.)

P. Well, I think this . . . woman is the husband of the man, and I think she's telling him that she's going to divorce him. And he's trying to talk to her and talk her out of it. But . . . I think she wins, she gets her own way and gets a divorce.

(Picture 7GF.)

P. I think this little girl is growing up and she's . . . and her mother is telling her about the facts of life . . . reading to her, and telling her . . . things that she probably asked about, with the doll in her arm, about babies and all. And I think her mother is reading her the important things about life. And I think the little girl . . . probably will . . . grow up . . . to understand all those things.

(Picture 8GF.)

P. This looks like a mother who . . . a . . . is thinking about her children or her son . . . in the Service, probably, or someone who has gone away. And she . . . a . . . looks as though she's worried about him, or he or she, but . . . I hope—I imagine everything will be all right, because all . . . mothers worry about their children.

(Picture 9GF.)

P. This looks like a young girl who is running away from her . . . mother, or trying to run out to meet someone, and the mother is—catches her leaving . . . and I wonder . . . what the outcome is going to be. Probably to meet a boy friend. And she, she probably follows her all the way. Spying on her.

E. Well, how does it finally come out?

P. Well, I imagine the mother just lets her go. That's about all.

(Picture 10.)

P. This looks like a . . . couple in love. Probably engaged, probably going to get married . . . and they're very much in love with each other. And they want to be together all the time. And they get married. That's the outcome. Is that all?

- E. That's all for that one. See, that wasn't so bad.
P. How was my imagination? Any good? Why don't you tell me that?
E. Well, we can't just read it off . . .
P. Oh, I see.
E. Have to go back over it and study . . .
P. I imagine every time you look at those pictures you imagine something different yourself, don't you? (*Half-laugh.*)
E. Now the next thing we'll do, we need a table for . . .
P. You don't have any aspirin in this building, do you?
E. No, I don't . . .
P. I have a terrible headache.
E. . . . know where any is.
P. Just pounding.

Transcript of Picture-Arrangement Test ⁷

- E. Now, this is a . . . well, it's called a picture-arrangement test. Here's a sample.
P. What is it, a puzzle?
E. Sort of. The pictures tell a story about a bird building its nest. As you see, they are in the wrong order, but if you put them in the right order, the pictures will tell a sensible story. In the first picture the bird is building its nest; the next picture shows the eggs that the bird has laid; and the last picture shows the bird feeding its young . . . have been hatched. Now I have some other sets of pictures that I want you to arrange. In each case they are mixed up and what I want you to do is to put them in the right order, so that they make the most sensible story. All right, try this set.⁸ (*Pause, rustling of papers.*)
P. Is there a certain time on these, you have?
E. No, I just keep track of how long it does take you. (*Long pause.*)
P. (*Unintelligible.*)

⁷ Cf. Wechsler (1944); and Wechsler (1946). Rapaport, Gill, and Schafer (1945, Vol. I, pp. 215-220) stress the importance of planning and anticipation in the picture-arrangement test. Dollard and Miller (1950, pp. 110-115, 200-214, 324-325) show how reasoning and planning may be disrupted by repression.

⁸ These instructions are adapted from D. Wechsler, *The Measurement of Adult Intelligence*. Copyright 1944 by David Wechsler. Reprinted by permission of the author.

- E. Tell me when you're done on the rest of them so that I'll know whether you're through, or whether you're still looking.
- P. Still looking . . . Oh, I see, all right.
- E. I could tell on that, but sometimes . . .
- P. Um hum.
- E. It's hard to tell.
- P. (*Pause.*) . . . get these closer. (*Long pause.*) Am I doing them right?
- E. Well, I should think you would know.
- P. Well I do, but I wanted to hear from you. (*Long pause.*)
- Mrs. B.'s arrangement of the pictures was as follows:

<i>Set</i>	<i>Arrangement</i>	<i>Time</i>
1. Elevator	LMNO	7 seconds
2. House	PAT	8 seconds
3. Hold up	ABCD	8 seconds
4. Flirt	JNAET	35 seconds
5. Gardener	FISHER	38 seconds
6. Taxi	SALUEM	29 seconds
7. Fish	IEGJFH	29 seconds

- E. Well, you did quite well on that. I don't see that there was any reason why you should have been afraid to take these tests.
- P. But it . . . I didn't know what to expect.
- E. Yes, that's true.
- P. And the anticipation was . . . is usually worse than the actual . . . operation.

Transcript of Rosenzweig Picture-Frustration Test⁹

- E. Now, . . . let's see how this thing is going off . . . here's a test that was prepared so that you would write out under each of the pictures what each of the characters says. They . . . each of these blocks here shows one person saying something to the second person . . . tells what the first person says and then you tell me what you think the other person would reply.
- P. You mean I don't have to write it, I just tell you.
- E. You don't write it out . . . that won't be necessary. Here. One
- ⁹ Cf. Rosenzweig (1945) and Rosenzweig, Fleming, and Clarke (1947).

person is always shown talking to another. Tell me the very first reply that comes into your mind for the other person. Avoid being humorous.

P. Avoid being humorous?

E. Yes, just say what you think the person would really say.

P. Oh, I see. Un huh.

E. And if you will read me what is written there.

P. Then you'll be able to understand what I'm talking about.

E. Then I'll be able to understand the reply. So just read that out loud.

(Picture 1.)

P. "I'm very sorry we splashed your clothing just now, though we tried hard to avoid the puddle."¹⁰

Well, it was my fault because I . . . didn't know where I was walking. Shall I go on to the next one?

E. Yes, just go right ahead.

(Picture 2.)

P. "How awful! How awful! That was my mother's favorite vase you just broke."

Well, I'd like to replace it if I could.

(Picture 3.)

P. "You can't see a thing?"

I wish that woman would take her hat off in front of me.

(Picture 4.)

P. "It's a shame my car had to break down and make you miss your train."

Well, I should have taken a taxicab.

(Picture 5.)

P. "This is the third time I've had to bring this brand new watch, which I bought only a week ago. It always stops as soon as I get home."

Either there's something wrong with . . . the way you handle it, or . . . there's something in your home that makes it stop.

(Picture 6.)

P. "The library rules permit you to take only two books at a time."

Well then, I'll take the other ones back.

¹⁰ This and subsequent quotations in this test are from S. Rosenzweig, *Rosenzweig P-F Study (Revised Form for Adults)*. Copyright 1948 by Saul Rosenzweig. Reprinted by permission of the author.

(Picture 7.)

P. "Aren't you being . . . aren't you being a little too fussy?"

No, I like things the way they're supposed to be.

(Picture 8.)

P. "Your girl friend invited me to the dance tonight. She said you weren't going."

That's right, I have another appointment.

(Picture 9.)

P. "Perhaps you do need your umbrella, but you will have to wait until this afternoon when the manager comes."

Well, it's raining out now and I would like to have it because I need it.

(Picture 10.)

P. "You are a liar and you know it."

That is not true; I never lie.

(Picture 11.)

P. "Pardon me, the operator gave me the wrong number."

That's all right. Just don't worry about it.

(Picture 12.)

P. "If this isn't your hat, Fred Smith must have walked off with it by mistake and left his."

Well, I'll take his and call Fred Smith.

(Picture 13.)

P. "I can't see you this morning even though we made the arrangement yesterday."

Well, I'm—I'll have to call you again for another appointment.

(Picture 14.)

P. "You should have been here ten minutes ago."

Well, the weather . . . was slippery driving and I couldn't make it.

(Picture 15.)

P. "Too bad, partner, we would—we'd have won after that swell play if I hadn't made that stupid mistake."

Don't think about it because we all make mistakes.

(Picture 16.)

P. "You had no right to pass . . . you had no right to try . . . and pass me."

That's right, I didn't have a right to pass you, on the wrong side.

(Picture 17.)

P. "This is a fine time to have lost the keys."

Well, I thought I had them in my pocket.

(Picture 18.)

P. "I'm sorry we just sold her the last one."

If you get any more let me know.

(Picture 19.)

P. "Where do you think you're going passing that school house at sixty miles an hour?"

I'm sorry oper-officer, I didn't realize it was a school house.

(Picture 20.)

P. "I wonder why she didn't invite us."

Well, maybe she wanted to have another group of friends in. Besides . . .

(Picture 21.)

P. "The woman about whom you are saying those things . . . mean things was in an accident yesterday, and is now in the hospital."

Well, that's too bad, I'm sorry we said the things we did.

(Picture 22.)

P. "Did you hurt yourself?"

Just slightly.

(Picture 23.)

P. "Is Auntie—It's Auntie; she wants us to wait while—a while until she can get here to give us her blessings again."

Well, we'll wait for ten minutes and then we'll leave.

(Picture 24.)

P. "Here's your newspaper I borrowed. I'm sorry the baby tore it."

Oh, that's all right. I'll get another one.

Transcript of Sentence-Completion Test ¹¹

E. O.K. Now, this next thing is an incomplete-sentences test and your job is to finish the sentences to express your real feelings. Be sure to make a complete sentence of each one. It's just the beginning of a

¹¹ The sentence-completion test was adapted from Rotter's test in J. B. Rotter, J. E. Rafferty, and E. Schachtitz. "Validation of the Rotter Incomplete Sentences Blank for College Screening." Copyright 1949 by the American Psychological Association. Reprinted by permission of Dr. Rotter, the *Journal of Consulting Psychology* and the Association.

sentence given here, which I'll read to you. And then you finish it. We'll go through them as quickly as we can.

(1) E. I like . . .

P. I beg your pardon.

E. I like . . .

P. I like? And then I have to make a sentence up?

E. You finish it. Just finish that, making a complete sentence out of it.

P. Oh. I like plays.

(2) E. The happiest time . . .

P. is when I was on a boat.

(3) E. I wish I had more . . .

P. money, to do the things I'd like to do.

(4) E. I want to know . . .

P. all about what's going on in the world.

(5) E. When I am alone . . .

P. I am lonesome and very lonely.

(6) E. Back home . . .

P. Back home? . . . (*Pause.*) Back home . . . I can't think of anything.

(7) E. I regret . . .

P. that I was unable to attend the meeting yesterday.

(8) E. At bedtime . . .

P. I can't wait to go to sleep. I'm so tired.

(9) E. Boys . . .

P. Boys?

E. Um hum.

P. Boys are . . . full of fun.

(10) E. The best . . .

P. is none too good.

(11) E. What annoys me . . .

P. is when people bother me. Or things.

(12) E. People . . .

P. are always butting into your business.

(13) E. A mother . . .

P. takes care of her family.

(14) E. I feel . . .

P. glad that I'm doing what I am.

- (15) E. My greatest fear . . .
P. is when . . . people are sick around me.
- (16) E. In school . . .
P. In school? The children learn a lot of things.
- (17) E. I can't . . .
P. get away for a day.
- (18) E. My stomach . . .
P. feels very good.
- (19) E. When I was a child . . .
P. I had a lot of fun.
- (20) E. My nerves . . .
P. are shot.
- (21) E. Other people . . .
P. always have a good time.
- (22) E. I suffer . . .
P. when things go wrong.
- (23) E. I failed . . .
P. to get the answer straight.
- (24) E. The most dangerous . . .
P. The most dangerous . . . the most dangerous thing is . . .
crossing streets.
- (25) E. My mind . . .
P. is always working.
- (26) E. The future . . .
P. is very blank.
- (27) E. I need . . .
P. a day of vacation.
- (28) E. A husband . . .
P. is a very important person.
- (29) E. I am best when . . .
P. I can be left alone.
- (30) E. Sometimes . . .
P. I like to ride in the country.
- (31) E. What pains me . . .
P. is when I hear of . . . illness.
- (32) E. I hate . . .
P. . . . liver.

- (33) E. I am very . . .
P. happy.
- (34) E. The only trouble . . .
P. The only trouble is that she didn't come when I called her.
- (35) E. I wish . . .
P. I had a million dollars.
- (36) E. By myself . . .
P. I like to do the things I want to.
- (37) E. My father . . .
P. is dead.
- (38) E. My ambition is . . .
P. to accomplish something.
- (39) E. I secretly . . .
P. hope for a better time.
- (40) E. I . . .
P. hope we have peace.
- (41) E. Dancing . . .
P. is fun when you're young.
- (42) E. My greatest worry is . . .
P. getting up in the morning.
- (43) E. Most men . . .
P. have a tough struggle.

Transcript of Word-Association Test ¹²

E: All right, that's all of that one. Now, here's another one which is a kind of word test. I am going to call out a list of words to you, one at a time. After you hear each word I want you to call out one other word. It doesn't matter what the word you call out is, but it should be the first word that comes into your mind after you hear my word. I should like you to call out your words as fast as you can so that we'll get through the list as quickly as possible.¹³

- | | |
|---------------------------|-------------------------|
| (1) E. World. | (2) E. Kill. |
| P. <i>Event.</i> (1 sec.) | P. <i>Die.</i> (1 sec.) |

¹² The word list is adapted from Orbison's word-association test in D. Rapaport, M. Gill, and R. Schafer. *Diagnostic Psychological Testing*, Vol. 2, p. 84. Copyright 1946 by Year Book Publishers. By permission of the authors and publisher.

¹³ These instructions are adapted from R. Schafer, "A Study in Thought Processes in a Word-Association Test," p. 213. Copyright 1945 by Duke University Press.

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|--|--|
| (3) E. Love.
P. Hate. (1 sec.) | (21) E. Bowl.
P. Spoon. (3 sec.) |
| (4) E. Father.
P. Mother. (1 sec.) | (22) E. Suicide.
P. Gas. (2 sec.) |
| (5) E. Hat.
P. Coat. (1 sec.) | (23) E. Mountain.
P. River. (3 sec.) |
| (6) E. Breast.
P. Breast? Stomach. (2 sec.) | (24) E. House.
P. Yard. (2 sec.) |
| (7) E. Curtains.
P. Shades. (1 sec.) | (25) E. Paper.
P. Pencil. (3 sec.) |
| (8) E. Fight.
P. Win. (1 sec.) | (26) E. Homosexual.
P. Two personality. (2 sec.) |
| (9) E. Trunk.
P. Suitcase. (1 sec.) | (27) E. Radiator.
P. Heat. (1 sec.) |
| (10) E. Drink.
P. Water. (1 sec.) | (28) E. Girl friend.
P. Boy friend. (3 sec.) |
| (11) E. Party.
P. Fun. (1 sec.) | (29) E. Screen.
P. Shade. (2 sec.) |
| (12) E. Book.
P. Paper. (1 sec.) | (30) E. Frame.
P. Picture. (1 sec.) |
| (13) E. Lamp.
P. Light. (1 sec.) | (31) E. Man.
P. Mend? Did you say?
(1 sec.) |
| (14) E. Rug.
P. Floor. (2 sec.) | E. Man.
P. Oh, man. Woman.
(3 sec., total time from
original stimulus.) |
| (15) E. Chair.
P. Seat. (1 sec.) | (32) E. Orgasm.
P. Release. (2 sec.) |
| (16) E. Boy friend.
P. Girl friend. (1 sec.) | (33) E. Movies.
P. Pictures. (2 sec.) |
| (17) E. Dark.
P. Light. (1 sec.) | (34) E. Cut.
P. Sore. (1 sec.) |
| (18) E. Depressed.
P. Happy. (1 sec.) | (35) E. Laugh.
P. Laugh? (1 sec.) |
| (19) E. Spring.
P. You mean, spring water? (2 sec.) | E. Laugh.
P. You mean to laugh?
(2 sec.) |
| (20) E. Ask.
P. Tell. (2 sec.) | |

- E. To laugh. (50) E. Suck.
 P. Oh. Happy. P. Jaw. (2 sec.)
 (6 sec., total time from original stimulus.) (51) E. Snob.
 P. Prig. (4 sec.)
- (36) E. Bite. (52) E. Horse.
 P. Chew. (1 sec.) P. Mare. (2 sec.)
- (37) E. Woman. (53) E. Fire.
 P. Man. (1 sec.) P. Burn. (2 sec.)
- (38) E. Lose. (54) E. Achieve.
 P. Find. (1 sec.) P. Accomplish. (2 sec.)
- (39) E. Dance. (55) E. Farm.
 P. Tap. (4 sec.) P. Barn. (2 sec.)
- (40) E. Dog. (56) E. Social.
 P. Cat. (1 sec.) P. . . . Party. (5 sec.)
- (41) E. Daughter. (57) E. Son.
 P. . . . Son. (5 sec.) P. Daughter. (1 sec.)
- (42) E. Taxi. (58) E. Taxes.
 P. Automobile. (1 sec.) P. Payments. (2 sec.)
- (43) E. Mother. (59) E. Tobacco.
 P. Father. (2 sec.) P. Cigarette. (1 sec.)
- (44) E. Table. (60) E. City.
 P. Chair. (1 sec.) P. Town. (1 sec.)
- (45) E. Beef. (61) E. Win.
 P. Meat. (1 sec.) P. Lose. (1 sec.)
- (46) E. Nipple. (62) E. Hospital.
 P. Bottle. (1 sec.) P. Sickness. (1 sec.)
- (47) E. Alone. (63) E. Doctor.
 P. Lonesome. (2 sec.) P. Helpful. (1 sec.)
- (48) E. Race. (64) E. Praise.
 P. Win. (3 sec.) P. Flatter. (4 sec.)
- (49) E. Water.
 P. Cold. (2 sec.)

E. All right, that's fine . . . in good time. Now I think we will find that these tests will help us to learn a little bit about you. Also it's helpful to us to find out what different people do on these tests, what kinds of answers they give.

- P. Do you give them a rating, or . . . or is it just for your own personal . . .
- E. Well, some of these . . .
- P. I mean, they're not like an I. Q. test.
- E. No, they're not like an I. Q. test.
- P. No, you don't have to have a rating of what your I. Q. is or anything.
- E. No, it doesn't give us an I. Q. It just tells us something about the different ways that different people respond, depending on their background, the kind of life they've lived, the way they look at things, the way they see the world. Different people will approach these tests in different ways.
- P. In different ways. I was just going to say, does this have anything to do with the treatment that I'm going to get?
- E. Well, I think it will be of some help to . . .
- P. It will.
- E. to the doctor.
- P. You'll report to the doctor and then he probably knows more about me, is that it?
- E. Yes. And he'll make what use of it he can to . . .
- P. It's really an interesting . . . test. I didn't realize that they gave those. And do all—do you always have to go through this when you're getting psychiatric treatment?
- E. Well, it . . . it depends of course on the psychiatrist. Many psychiatrists do . . .
- P. Give this test?
- E. give you tests.
- P. Um humm.
- E. Like this. Perhaps not the same tests, but similar ones.
- P. Oh, I see.
- E. Quite a few psychiatrists are using them.
- P. Well, does it . . . it really is a very good thing, I think.
- E. Well, I think the doctor will be along in a few minutes.
- P. All right.
- E. So I'll leave you now.
- P. All right, fine.

THE TEST REPORTS

Could the psychological tests given to Mrs. B. have been helpful to the therapist? Would they have prepared him for the behavior she exhibited in the therapy? To answer these questions we asked two colleagues—clinical psychologists who are well trained and experienced in the interpretation of psychological tests—to write out interpretations of the projective tests given to Mrs. B. We asked them, in particular, for a description of the patient's personality and an evaluation of her suitability for psychotherapy. Their reports are printed in full in this chapter.¹

We realize that the criterion of the conduct of the interviews and our evaluation of the interview data in this one case are far from ideal. Others might have handled the therapeutic relationship differently and, hence, their evaluations of Mrs. B.'s behavior might have been different to some extent. The reader who has never had experience with therapy might suppose, indeed, that the patient's problems will appear in quite a different light if the therapist makes some change in technique, that the therapist, as it were, can impose a certain kind of construction on the patient and force the patient's problems into a mold. Those who have worked most closely with neurotic patients know that this is not so. The therapist's interventions do affect the

¹ We express our heartfelt thanks to Dr. X. and Dr. Y. for their workmanlike devotion to science in permitting these reports to be used. Both courage and scientific temperament are required in submitting one's clinical skills to this kind of relentless public examination. There must be psychologists willing to do this if we are to transform the art of testing into a science.

patient's responses and influence to some degree the order in which topics come up (we have emphasized these points in earlier chapters). But interpretations are not accepted and assimilated by a patient unless they prove genuinely useful in daily life; and the conflicts of the patient are not caused to disappear if the therapist should fail to note them, nor are they created by any intervention of the therapist. Thus we believe it unlikely that Mrs. B. and her knotty problems would have changed when confronted with different therapeutic techniques. All forms of insight therapy have much in common and would have produced some of the factors brought out by our therapy. The interactive episodes might have appeared in a different order because of a different approach by the therapist. Depending on the therapist's behavior, some of the relevant responses might have been neglected or suppressed, but it is our belief that many or most of the same responses would have been made by the patient. The criterion of the psychotherapeutic interviews is obviously appropriate for judging the probable usefulness of the projective tests in the case of Mrs. B.

WHAT THE INTERPRETERS KNEW

One of our colleagues, Dr. X., had at his disposal a written transcript of the tests, a sound recording of the tests, and a summary of the psychiatrist's initial interview. This summary was as follows:

This patient is an attractive, forty-year-old, married woman. She reports that she has been feeling depressed and having crying spells. For the past two weeks she has felt quite beside herself—"as though the world were coming to an end" for her. The patient says that her father died when she was ten, and she remembers him as a kind, gentle man. She married at the age of 24. Since she felt she could not leave her mother, she and her husband lived in her mother's home. Her mother took over the upbringing of their son and daughter. The patient feels strong resentment toward her mother about this because she has "no close relationship" to her own children. The boy is now twelve and the girl fourteen. The patient says that she "just hates her mother."

Dr. X. was asked for a description of the patient's personality and an evaluation of her suitability for psychotherapy; he did not know beforehand that his report would be used in research. After he had made his interpretation, we disclosed our research motivation for getting his report, and he gave his consent to our use of it in this chapter.

Having access to some material from the initial interview, Dr. X. had approximately the same information that psychologists working in clinics or in private practice usually obtain when they interpret psychological tests.

The psychologist gets many impressions from this additional knowledge about the patient, and these impressions (as the reader will be able to judge) greatly influence his interpretations of the tests. For this reason, we decided to ask a second clinical psychologist to interpret the test without access to any case material. This colleague, Dr. Y., had at his disposal a written transcript of the tests, the sound recording of the tests, and only the following limited data: the sex and age of the patient, whether parents are dead or separated, ages and sexes of siblings, patient's vocation, and marital status. We asked Dr. Y. for a description of Mrs. B.'s personality and an evaluation of her suitability for therapy. We told him in advance of the research use to which his report would be put. He has given his consent to our use of his report in this chapter.

Psychological Report by Dr. X.

ANALYSIS OF TEST RESULTS

A battery of tests that is regularly used by most clinical psychologists to derive the information requested was not given.² This makes interpretation difficult. I would have used as a minimum the complete Wechsler-Bellevue Scale, the complete T.A.T., and the Rorschach test. However, within the limitations of the procedures used and the very small sample of behavior which they include, it is possible to make some inferences about personality content and structure which might be of help in future psychotherapy.

The patient seemed extremely apprehensive and she was suspicious of the procedures being used. She was very concerned about following the directions and needed much prompting and encouragement. Her wary attitude appeared to stem from the fact that it was a new kind of situation for her, and she felt she was not in complete control, and she might reveal herself without being aware of it. Such an attitude,

² *Author's note:* This is true but irrelevant. The purpose of this research was to gather evidence about the validity of five tests: the first half of the T.A.T., a picture-arrangement test, the Rosenzweig test, a sentence-completion test, and a word-association test. Dr. X. did not know the purpose of the study when he wrote his test report.

if carried over to the therapy situation, would conceivably hinder progress if not handled tactfully by the therapist and if he were not able to gain her confidence rapidly. She made a number of self-disparaging statements throughout the testing and seemed anxious to have the examiner tell her she was doing well. In therapy it would appear she would need constant encouragement. During the test situation when the going got a little tough and she was in suspense over what the next procedure would be, she developed a headache and asked the examiner to obtain some aspirins for her. It thus may be predicted that under stress she will fall back on somatic symptoms as a rationalization for her own felt inadequacies.

Her relationship with her mother seems to be the focus of many of her difficulties. She still chafes at parental restrictions and has not yet resolved her separation from her mother's influence. She feels she has been pushed by her mother and has tried to live up to her aspirations, but somehow can't accept the mother's goals as her own. She resents the mother's interference in her personal life. She feels somehow that her mother has kept her from her father—perhaps blaming the mother for her father's early death and his consequent separation from her. In other words, it's the mother's fault that the father died as she wanted to keep them separated. She still sees the mother as a rival in the heterosexual situation. Confusion in her sexual identification, which also may be related to the early withdrawal of the father from the home, is suggested by some unusual slips of the tongue and her blocking on the words "boy" and "man" in the sentence-completions and word-association tests. A story in the T.A.T. that was accompanied by depressed feeling tone concerned a mother giving sex instructions to her daughter and the little girl "grows up to understand those things." The wistful sigh at the end of the story suggests that this is a wish fulfillment fantasy compensating for the lack of any such orientation given her by her own mother (and perhaps a recognition of the same shortcoming in her relationship with her own daughter).

Her relationship with her husband is also an area of concern. It is possible that she is suspicious of her husband's philandering, reacts with hostility to this and then feels guilty over her hostile wishes. The marked inadequacy feelings, especially over her felt intellectual shortcomings, may also be tied up with the marital situation (perhaps because of a difference in educational level from that of her husband).

She is a woman who has difficulty in recognizing and expressing her aggressive needs. Her frustration tolerance is low and when frustrated she usually turns the resultant aggression against herself and/or tries to gloss over the frustrating circumstances. She tends to blame herself or make excuses for frustration. She feels guilty over the expression of any hostility on her part.

The future is very uncertain for her and she worries about it. In retrospect, childhood seems safe and happy to her. Pleasure and fun are things which she identifies with childhood and other people but not with herself at present. But that a great deal of repression for her own childhood has set in is suggested by the inability to respond in the sentence completion to the phrase, "back home." Thus the rosy regressive wishes would hardly seem to be realistic.

She states that she feels lonesome when she is alone, yet paradoxically, she also says she feels best when she is left alone. She states too that "*People are always butting into your business.*" This seems indirectly to be a rebuke at the examiner and reinforces the impression that therapy with this woman would be difficult because of her feeling that the therapist would be prying into her affairs.

Because of the paucity of the psychological test record, confirmatory evidence of many of the above impressions could not always be found. It is felt, however, that there are sufficient leads here for psychotherapy. Whether or not this woman is treatable, however, and what the prospects are for the success of insight therapy cannot be stated without further testing (Rorschach and complete T.A.T.).

Psychological Report by Dr. Y.

BEHAVIORAL OBSERVATIONS

The patient entered into the testing sessions with considerable evidence of overt anxiety which persisted through most of the testing session but showed some abatement at the close when she was reassured that the tests may be helpful in her therapy. Her initial anxiety was so overwhelming that on the first psychological test, the Thematic Apperception Test, the patient misinterpreted the directions given by the examiner by looking at the card for three minutes rather than taking the three minutes to verbalize a story. It may thus be inferred that facing a new situation is a difficult and unpleasant task for her. However, there was some indication that as the task becomes more

structured and more anchored to previous experience, she is likely to experience less anxiety.

The experience of taking the first test may have been so disturbing as to have resulted in a somatic complaint (headache). This may either have been a reaction to the difficulty or even more specifically may have been an attempt to escape from a threatening situation. The extent of her anxiety was such that she would ask questions of the examiner to clarify the nature of an impending test even before the examiner had quite completed his instructions. This pressure or need to question the examiner would suggest that anxiety cannot be effectively controlled.

On the whole the patient attempted to be pleasant, cooperative, and to meet the demands of the situation. However, she was self-critical of her functioning and frequently reflected her dependence on the examiner by asking if her performance was satisfactory. This would suggest that the patient is lacking in her resources to evaluate herself effectively and must constantly seek outside confirmation for the adequacy of her functioning.

A self-punitive attitude appeared when the patient apparently evaluated her inability to comprehend adequately instructions as being due to her fault and as a consequence used the expression, "I beg your pardon." This also had the implication that she was concerned about not offending the examiner, and it would therefore be suggested that this woman has strong needs for social approval. Generally speaking she tended to view the psychological tests as a medium by which her intellectual competence could be evaluated. This would suggest that intellectual ability and her attitudes toward it constitute a source of difficulty with her.

PICTURE-ARRANGEMENT TEST

On the picture-arrangement subtest of the Wechsler-Bellevue the patient performed on a level comparable to that of a person of high average intelligence. While it is difficult to evaluate her global intellectual functioning on the basis of this single subtest, it is probable that this represents her minimal intellectual capacity. However, no estimate of optimal level can be established. The limited evidence in this subtest does not support the possibility that there exists any gross thinking disorder. The patient apparently can perceive relationships ade-

quately, and the social implications of these relationships are not of such nature as to disrupt her thinking processes. While she does poorly on one of the items of this test which may be considered to be charged with sexual content, this item is among the more difficult items in the series and it would be difficult to attribute her poor performance here entirely to the effect of sexual disturbance within her.

It was noted that the patient did not respond with any humor to the items in this subtest. It is frequently noted that adults will perceive the humorous implications in several of these situations and respond appropriately to them. The failure on her part to do so would suggest that her threshold for the perception of the humorous implications in a social situation is rather high. Since humor so frequently serves as a vehicle to free repressed aggression in a sublimated form, it is therefore suggested that this woman's aggressive tensions are so dammed up that they cannot even be expressed at this level.

THE ROSENZWEIG PICTURE-FRUSTRATION STUDY

The study reveals that this woman's characteristic mode of reaction to frustration is to direct censure against herself. Many of her responses reveal this tendency to blame and self-depreciate herself with the development of guilt or inferiority. There is very little attempt to mobilize her aggressions so as to direct them to objects in the environment. She frequently finds the experiencing of guilt so uncomfortable that in order to assuage it she undertakes to solve the frustrating problem. Her first response on this test was a definitely intropunitive response but the extent to which she is immobilized by her aggressions even though internally directed is suggested by her response here, "I didn't know where I was walking." When severely frustrated, she may show signs of irritation but rarely any direct expression of her hostility. Even in one situation where she attempted to direct aggression toward a human, this became so anxiety provoking that she found it necessary to change the object of her aggression to a nonhuman aspect. Thus in response to one frustration she states, "There is something wrong with the way you handled it or there's something wrong in your home."

There is a suggestion that the presence of authority figures may produce considerable anxiety. Thus in response to a test item that figured a police officer the patient responded initially to the officer with the expression "oper" but then correctly changed it.

The general intro-punitive manner in which this woman handles her aggressions does not imply that at all times her behavior will be characterized by this method of defense. It may be that this characteristic method of handling aggressions may represent primarily her fantasy behavior rather than her overt behavior although it is probable that this pattern will run into both aspects.

THE WORD-ASSOCIATION TEST

The test suggests several areas of conflict. The area of orality and its implications for dependency seem to be a focus of conflict. The patient blocked on the word "breast" and then finally responded with "stomach." There is some indication that dependency may be fused with aggression in her response "jaw" to the word "suck."

The patient responded "win" to the word "fight" which would suggest that the stimulation of aggression arouses the need for success. It would seem therefore that a very strong competitive factor is operative in her personality and this competitive factor is aroused by aggressive tension. The strong need to succeed in competitive activity is again suggested by the association "race-win."

The patient misinterpreted the word "man" to mean "mend." This association of a feminine activity with man suggests some confusion in the area of sexual identification. This is further reinforced by the association "homosexual—two personality," which in addition suggests the possibility that this woman has need to display a double personality in order to conceal the homosexual trends within her personality.

The word "laugh" produced blocking which suggests that the experiencing of feelings of elation is not only difficult but should also be avoided, perhaps because of the strong self-punitive attitude. There was a considerable delay to the word "daughter" which may be related to her relationship to the mother. Similarly there was a delay in response to the word "social" which may indicate that contact with people is anxiety provoking. Her response "doctor—helpful" would indicate that she looks positively on the therapeutic relationship with the doctor.

SENTENCE-COMPLETION TEST

The areas of affection and hostility appear to emerge as major areas of disturbance for the patient. The patient blocked on completing the sentence beginning with "I like" which implies that the expression of

affection is for her a very difficult experience. The completion to this association—"plays"—suggests a clue toward understanding her inability to express affection. She was unable to name any person in this association. Her hostility is revealed at several points in this test. She blocks on the association "the most dangerous" but then finally concludes "thing is crossing streets." Since the chief danger that may result to anyone crossing streets is in injury from automobile accidents, it may be hypothesized that here she was permitting a very minimal level of aggression to be expressed tangentially. This inability to direct hostility toward people outwardly is further supported by her response, "My greatest fear is when people are sick around me," which most probably represents the guilt that she experiences as a result of her aggressive feelings. Because of her inability to express aggression outwardly she finds it necessary to punish herself for her failure. ("I suffer when things go wrong.") The patient gave the response "I hate liver" with some lapse of time between the stimulus and the response. Here again is further evidence of an inability to express aggression toward people along with dependence on them (shown by the food response), which she has not as yet been able to overthrow. One aspect of her hostility is revealed in her viewing others as being more fortunate or more successful as competitors, "Other people always have a good time."

Because of the dangerous implications to her of her aggressive feelings, the patient seeks to avoid contact with others. Thus she expresses happiness "when I was on the boat," presumably in a state of isolation from others around her, and "I am best when I can be left alone" also indicates that she is "best" or good when she does not have to be in contact with others. Contact, in other words, is presumably dangerous. Her preference for socially isolated activities is again seen in her response, "Sometimes I like to ride in the country." She views people as forces of interference. ("What annoys me is when people bother me." "People are always butting into your business.") Thus they become for her sources of discomfort and an irritating force. One form of escape may be in sleep where she can avoid the necessity for contact with people and the implications of such contact. ("At bedtime I can't wait to go to sleep.") This response may also suggest that withdrawing into a passive, dependency relationship nevertheless for her performs a security function even though she apparently is actively struggling against such a relationship. While she actively struggles to

escape from social contacts, she feels that she is unable to do so. ("I can't get away for a day.") However, while she seeks to be away from people, being away from them does not really solve her problem and she experiences a severe loneliness problem. ("When I am alone I am lonesome and very lonely.") She is thus in a constant state of tension which she is unable to cope with successfully. ("My nerves are shot.") Furthermore, her outlook toward the future is dismal and bleak. ("The future is very blank.") While giving expression to her despair, this also may reflect a desire to avoid the future and the responsibilities that it implies for her. This is implied by her response, "My greatest worry is getting up in the morning," which suggests either her fear of death or her concern about meeting each day's responsibilities or possibly both. Striving for accomplishment and inability to attain such accomplishment seem to be another important focus of maladjustment. Part of this frustration may be a result of the standards that she has set for herself which are beyond accomplishment. This is implied by her response, "The best is none too good." Thus whatever may be achieved still may be insufficient to satisfy her needs. Her inability to accomplish success is further demonstrated by her response, "My ambition is to accomplish something." It would seem that one significant area of frustration is in the area of intellectual achievement. Thus she states, "I failed to get the answer straight," thereby associating failure with intellectual incompetence. The area of schooling is also disturbing and further suggests that intellectual accomplishment is for her a serious problem. In response to the association "in school" the patient blocked before proceeding with a satisfactory completion. The implications of school as a real experience in the tasting of success and failure would seem significant for this woman. Thus one finds a striving on her part to learn and master the facts about the world, "I want to know all about what's going on in the world"; but this may also represent a defense against knowing people, for to know facts may be much less dangerous than to get to know people on an intimate level.

That her early childhood is a factor in the present development of her emotional problems is suggested by her response, "When I was a child I had a lot of fun," a response implying that the present does not hold such enjoyment for her. This may also reflect a preference for a return to the earlier patterns of behavior. This inability to see fun in the present is also supported by her response, "Dancing is fun

when you're young." This response, however, has the further implication that dancing as an expression of physical contact with another human being is not a pleasant experience but rather may be intolerable. This intolerable present is therefore an experience from which she would like to escape. "I need a day of vacation" also reflects her desire to escape; yet her stress on the "one day" shows that she is still unable completely to throw off the yoke of her responsibilities. She is preoccupied and obsessed with her problems ("My mind is always working"), and this may account in part for the stress on the feeling of fatigue that she experiences.

Her response, "A mother takes care of her family," may imply that she looks upon her role as a mother as unsuccessful or that she is attempting to fight against such a role herself. This interpretation is supported by her statement, "A husband is a very important person," which by inference would imply that the wife is less important. She thus appears here to degrade the significance of her role. She appears to be a narcissistic person who desires to see the world about her respond to her wishes and needs. ("The only trouble is she didn't come when I called her.") In reference to her masculinity strivings, it may be noted that her response "Boys are full of fun" may imply that masculinity is a more enjoyable role than femininity. While there seems to be this desire to assume a more masculine role, she is not able to express any affectionate feelings toward her father. The response that she gave to the association "my father" was "is dead."

While she appears to possess little insight into the nature of her difficulties, seeing many of her problems solved by the acquisition of money, she nevertheless expresses a positive attitude toward therapy.

THEMATIC APPERCEPTION TEST

While the patient's stories to the Thematic Apperception Test were rather brief, she attempted to comply with all of the instructions for the most part. There seemed to be considerable fearfulness in expressing her fantasy with the obvious implication that by doing so she will be opening herself to examination by others. Thus she frequently used the term "probably" to qualify her interpretations of pictures and thus avoid complete responsibility for her material. Feelings of unhappiness pervade the entire record. The main characters of her stories are "unhappy," "frightened," and "emotionally upset."

The parents are seen as individuals who make demands on children. ("He is forced to take lessons, . . . She has to go to school.") While she actively struggles against compliance with parental demands, she nevertheless feels powerless to overthrow the dependency relationship that they foster. Thus in one story, a heroine accedes to the demands of the mother and pursues her education to completion. In another story the hero is not able to disregard completely the wishes of the parents. However, he is able to accomplish his ends by not learning what is expected of him while at the same time, on the surface, he appears to comply.

The mother is represented as being the more demanding of the two parental figures. She is a figure that stands between the patient's striving for heterosexuality and her accomplishing it. Thus in one story where a young girl is portrayed as going out to meet her boy friend, the mother is referred to as "spying" on the girl in order to intervene in this process. While the heroine accomplishes her purpose in meeting her boy friend, the patient stresses that this happens because the mother lets her go and not because the girl struggles against the mother. This would again affirm the proposition that the patient has not been able to struggle successfully against the dependency relationship with the parental figures. In one story a mother is described as giving information to a child but it is of interest that this information is not given spontaneously but as a result of the child asking questions. This would again suggest that the patient sees her mother as a person who, while sharing with the child, was not a person who spontaneously gave of herself.

The patient seems to be attracted to the father. In one story she describes a heroine who wishes to remain at home so she can go "plowing with her father." The specific use of this language has a sexual connotation and it may be that this is a representation of the oedipal conflict. However, in this same story the mother steps in as a thwarting agent who is able to banish the heroine from the home by sending her to school. In this particular story the heroine completes her education and becomes a schoolteacher. It may thus be hypothesized that the desire to acquire knowledge and intellectual competence may be a substitute for the earlier childhood patterns of attempting to acquire the father as a love object. While there is the expression of attachment to the father, the patient is apparently unsure of this relationship and

thus she has to qualify her statement of the father figure by stating, "If that is her father." The possibility that the father may have functioned in a rejecting role in this relationship is further suggested by the same story in which the father occupies a very passive role and his passivity may thus be interpreted as a rejection of the affection that the heroine feels for him.

Heterosexual relationships appear quite disturbed. In one story the husband is portrayed as a person who rejects the wife. He is unfaithful and is leaving her for another woman. Thus it may be inferred that the patient is experiencing feelings of rejection in her relationships with men and with it strong feelings of inferiority to other women who are capable of attracting men from her. Then in her next story aggression comes out; the husband is described as being dead although there exists no male figure in the picture. Two possible interpretations are suggested: either the patient rejects men to avoid being rejected by them, or she has already been rejected and is striking back at men. This story gave rise to expressions of fear and anxiety on the part of the heroine who expresses these feelings in the wake of her husband's death. This would suggest that the patient's hostility produces strong guilt feelings. Similarly, she ends another story by saying that the woman must suffer because "that's the way it goes." This is a rather fatalistic attitude toward the price she must pay for her aggressions. Her desire to isolate herself from others emerges in this story as a consequence of the expression of guilt toward the male. A positive attitude is apparent, however, when she states that the woman is "going into the world" as if to overcome the tremendous anxiety that has arisen. In the next story in the series the patient again reflects her hostility toward the male by telling a story involving the decision of a wife to divorce her husband. She describes the male as pleading for the wife to remain with him and it may be that one form that the patient's hostility takes is to place men in a position of inferiority to her. Her desire to dominate the male as well as to fulfill her narcissistic needs is indicated by the expression "She gets her own way." An interesting clue to why she stresses "winning" so much is in her statement in this story that "she wins" in referring to the woman's desire to divorce the man in the face of his pleading. It would thus seem that winning represents an attempt to conquer the male.

As a consequence of the basic relationships to the parental figures,

one finds her sexual role as being quite confused. She has difficulty in perceiving her own sexual role and moreover seems to be actively struggling against the role of femininity. Thus in one story she had difficulty beginning the story and shifted her verbalizations from man to woman and back. In another story she reveals this confusion by stating, "The woman is the husband of the man." Thus there is considerable struggle in clearly perceiving her own sexual identifications. Her understanding of sex and its implications appears to be unclear. She tells a story in which a young girl is being given the facts of life by the mother. In concluding the story she states that the girl will "*probably* grow up to understand all these things." This lack of certainty about whether the child will absorb and understand this information suggests that this parallels her feelings of insecurity in this area.

There is only one story pertaining to children and this produces the theme of a mother who is very worried about her children who have either gone into service or have gone away. This would suggest a fear of rejection by children and a sublimated expression of rejection on her own part. However, this story, as in many of the others, produces considerable anxiety and guilt but again in her same self-punitive manner she states, "All mothers worry about their children" as if this justifies the suffering that she may experience as a result of her rejection of her own child.

In one story, the patient equates sickness and death. The aggressive implications of this story produce considerable anxiety and the heroine is described as being unable to face the situation produced. As the story proceeds, a further equation is made between sickness, death, and rejection ("thrown out of her house"). The sequence of these equations would suggest that her hostility results in possible retaliatory rejection and therefore there may be fear in expressing aggression since this may serve as a basis for rejection.

INTEGRATIVE SUMMARY

The patient is a very self-critical and self-punishing individual who displayed considerable overt anxiety over which she is unable to exercise effective control. The nature of her anxiety appears to be related to strong guilt feelings emerging from strong aggressive tensions which she is unable to express overtly and consequently internalizes. Early parental relationships seem to have played a significant role in the

development of her present hostility problem. In part its genesis seems related to early dependency relationships, particularly with the mother, which she has been unable to relinquish. Hostility has developed from her inability to resolve her dependency conflict but hostility cannot be expressed overtly for fear of retaliatory rejection. Because of the fusion of dependency and love with hostility, the patient is unable to engage satisfactorily in warm, human relationships without the consequences of her hostility overwhelming her. As a consequence she attempts to avoid too intimate a relationship with people but this only intensifies her loneliness problem. Because of these disturbed childhood relationships, she is unable to engage in a mature heterosexual relationship. Her hostility toward her father, who apparently has served as a passive, rejecting figure, makes impossible the establishment of satisfactory heterosexual relationships. The fear that men will reject her as she has already experienced rejection by the father plays a prominent role in her fantasies. The mother too plays a role here, for she is perceived as a figure who thwarts and interferes with the legitimate heterosexual needs of the patient. Her only solution to this dilemma is to accentuate further her hostility toward people, but the anxiety generated by this is so guilt-provoking that this must be internalized, and internalized suffering is the result. While there is some ambivalence toward the future expressed by the patient, the motivating force of her anxiety together with the positive attitudes expressed toward the therapy may enable this patient to accomplish a great deal in psychotherapy. (*End of test reports.*)

Tests as a Guide to Therapeutic Strategy

The reader should ask himself: "Did the tests predict what occurred in therapy? Would the predictions or hypotheses in these reports have been useful to the therapist?" The fact that projective tests are so often used to diagnose suitability for treatment makes the psychotherapy situation a crucial place for validating them.

If the therapist acts on hypotheses presented by the tester and if they are correct, he should be able to start early on a constructive course of action. But if the tester's hypotheses are misleading, the therapist may be delayed and hindered because he is made to behave stupidly in the interactive process of psychotherapy. With many patients whose motivation for therapy is weak, the first hours of treatment are important.

These early hours can lead either to consolidation of the patient's wish for help or they can lead to a weakening of that wish.

If test reports are to be useful, the therapist must be able to act on the information given. He cannot suspend action until he finds which of several alternative possibilities are true. The hypotheses in a test report are put to work either to benefit or harm the patient in therapy. The tests are useful only if they give advance notice of coming events, problems, and attitudes.³ The tester cannot take credit for making some correct statements if at the same time he makes a good many wrong statements. If the therapist acts on the implications of test reports and if some of the predictions are wrong, he may be wrong a good part of the time. If half the information is correct and the other half incoherent, the therapist is just as likely to act on damaging hypotheses as he is on useful information. Test reports, then, are valuable to a therapist only when a high proportion of the statements made are correct. If it is answered that the tests are not the only basis of evaluation and action for the therapist, the situation remains unchanged. Either the tests strengthen correct courses of action and appropriate behavior or they weaken such evaluations and actions. We hope that the reader, as he evaluates the test reports on Mrs. B., will ask himself whether they would have strengthened correct courses of action and led to appropriate behavior by the therapist.

For our own part, we do not believe that the test reports would have been very helpful. We advance this opinion only tentatively, however, because it is difficult to judge how near the mark a tester hits with his interpretations. The test reports by Dr. X. and Dr. Y. offered a variety of hypotheses, some of which were apparently correct and some, incorrect. Possibly some might have proved correct if the therapy had been more extended, but the predicted traits did not appear during the seventeen hours of treatment. In some instances the test reports offered hypotheses that seemed ambiguous or involved alternatives that could not be of equal importance. Hypotheses were suggested without indicating which were more probable and which problem should be treated first.

The reader has no doubt already drawn his own conclusions as to their usefulness from his reading of the two test reports. Any impres-

³ Sears (1951, p. 478) has expressed the problem of making predictions from tests in terms of discovering from tests what the predispositions of the subject are.

sionistic opinion such as the reader will have from comparing the test reports with the therapeutic data, however, has serious drawbacks. When congruence of test reports and therapeutic findings is judged impressionistically, one is likely to notice correspondence and neglect differences. Furthermore, it is difficult to estimate the degree of congruence. Scientific study of how well test reports predict behavior in therapy must therefore make use of systematic, point-by-point comparison of statements in test reports and descriptions from therapeutic data. We did not attempt such a point-by-point analysis because to do so with only a single case would be pretentious—and misleading to the extent that the case is not representative.⁴ We are publishing the test material so as to draw the reader's attention to the problems involved and to provide an opportunity to discuss the general issues of predicting behavior from tests. In the pages that follow, we shall consider some general theoretical observations that were stimulated by our study of these reports in comparison with the detailed information in the therapeutic interviews.

WHAT ARE THE SOURCES OF TEST INTERPRETATIONS?

We believe it to be quite evident from the test reports by Dr. X. and Dr. Y. that the hypotheses offered by these clinical psychologists were derived not only from the patient's responses to the tests but also from various other sources. First of all, these testers knew that the person tested had come seeking help from a psychiatrist. Professional testers in a psychiatric clinic would know this in evaluating test reports on patients, of course. Yet if a tester knows this he could not be expected to give a completely unbiased opinion about a person tested.

A second source of hypotheses in the test reports was the behavior of the patient during testing, apart from what were, strictly speaking, "test responses." These incidentally observed responses during the testing often give valuable clues to the patient's personality.⁵ However, testers undoubtedly respond to cues from the incidental behavior of the patient during the testing session without full awareness that they are using these cues. In the case of Mrs. B., the test interpreters had a

⁴ The authors, in collaboration with Dr. Leonard D. Eron, are now engaged in a study of the predictive value of projective tests in the psychotherapy situation. We hope to have data based on a considerable number of cases so that we can conclude with some assurance whether the tests are useful or not.

⁵ Sarason (1951) has discussed this point.

sound recording and a written transcript of the testing session, but they did not have the opportunity to watch the patient's behavior and so were not able to use visual impressions as a source of inferences. But Dr. X. and Dr. Y. did comment upon Mrs. B.'s incidental responses as indications of her personality traits.

A third source of hypotheses in one report (that of Dr. X.) was the material from an initial interview with this patient. In many cases test interpreters routinely have access to the data in an initial interview, and we believe this can influence their evaluation of the test responses. We shall have more to say on this matter later.

These test reports show that the patient's cover story was another source of hypotheses. The responses of a patient to the test and the story that the patient tells in the initial interview may both be influenced by the patient's cover story. To understand how the cover story distorts the interpreter's view of the patient, we must turn for a moment to consider the theory of projective tests.

HOW DOES THE COVER STORY INFLUENCE THE TESTS?

Test interpreters make various assumptions concerning projective tests. The essential assumption, of course, is that unconscious forces produce telltale responses to the ambiguous stimuli of the test. It is further assumed that the subject's responses to the test are direct or indirect expressions of his response tendencies in some criterion situation. The critical situations of everyday life are for most people (and particularly for the neurotic) situations that involve conflict. In order to predict the overt responses that will occur in these situations the tester must know the strength of habits leading toward action and the strength of inhibitory or competing habits. From the test responses he tries to evaluate the balance of the positive and the inhibitory habits.

But the occurrence of responses to the tests is not entirely determined by drives related to the conflict—that is, by the drives that would cause the occurrence of a goal response in real life or would inhibit it. The occurrence of a response on the test may also be influenced by motives that are irrelevant to the real-life conflict. Whenever this situation obtains, the tester cannot use the test response as a direct index of the balance of positive and inhibitory tendencies. Everyone recognizes that personality questionnaires are subject to this kind of influence by extraneous motives of the patient, such as the motive to appear in a

better light. It is not widely appreciated, however, that projective methods are also subject to extraneous motives and that various tests differ in their susceptibility to influence by these extraneous motives.

Weisskopf and Dieppa (1951) found that subjects who were instructed to try to make the best impression possible on the T.A.T. could successfully influence the diagnosis of their personalities as made by experienced T.A.T. interpreters. These subjects were twenty-four hospitalized veterans, diagnosed as psychoneurotic, who had had no previous acquaintance with the T.A.T. A similar study by Meltzoff (1950) showed that replies to the sentence-completion test could also be faked. Sells (1952) reported that subjects given the Rorschach individually were more restrained in their answers than those who took the test in a group.

The influence of the extraneous motives can be either conscious or unconscious. Sometimes the patient knows facts about himself and deliberately misleads the psychologist. For example, he may realize to some extent that his answers to the Rosenzweig test reveal his own reaction patterns and may change his answers so as to make himself appear more favorably. In other instances, the patient does not consciously mislead. With all good intentions of being truthful and frank, he automatically reacts defensively. These defensive responses are not accompanied by parallel verbal responses and, therefore, can be described as "unconscious."

If these defensive responses were entirely motivated by the same inhibitory motivation that enters into the approach-avoidance conflict, the test results would not need to be distorted. The defensiveness could be considered an indication of the strength of the fear motivation in the approach-avoidance conflict. But these defensive responses have a motivation partly distinct from the fear element in the conflict, and therefore they cannot be taken as an index of this fear. Failure of the patient to make "approach" responses on the test does not necessarily indicate strong inhibition of the analogous response in real life. It may only indicate the inhibition of description or communication concerning these actions or any punishable actions. In other words, it may indicate a general defensiveness.

When a patient, as in the case of Mrs. B., has motives, conscious or unconscious, to conceal or fail to reveal herself and wants to sell the tester on her cover story, then the tests may not give a true picture of

the balance of forces in the personality. In this case, one cannot assume that the test responses were entirely determined by the balance of forces in the conflict. They were partly influenced by extraneous motives. Therefore, Mrs. B.'s cover story that she is a meek and inhibited person would influence her test responses.

Some projective tests seem to be more susceptible to influence by extraneous motives than other tests. The test reports just presented give preliminary evidence that the Rosenzweig test and the sentence-completion test are more subject to these influences than the T.A.T. and suggest that these more easily influenced tests give the subject more cues to which defensive habits have been learned.⁶

INFLUENCE OF INITIAL INTERVIEW ON TEST INTERPRETATIONS

The test reports on Mrs. B. also seem to show that a tester who has access to notes on the initial interview with the patient (as Dr. X. did) is more likely to be influenced by the patient's cover story. When we compare Dr. X.'s report with Dr. Y.'s, we notice that Dr. X.'s report matches Mrs. B.'s cover story much more closely. He believed the "mother is to blame" theme and used it in writing up his test report. Dr. X. said that Mrs. B. had not freed herself of her mother's influence and (this was one of her complaints in the initial interview) that she resented her mother's interference in her personal life. He said that she "feels pushed by her mother but can't accept her mother's goal for her." Dr. Y., not having access to material from the initial interview, did not take up the "mother is to blame" theme.

SUGGESTIONS FROM OUR EXPLORATORY STUDY OF TEST REPORTS

We believe that two important observations may be made after comparing the two test reports in this case. The first observation is that some of the test responses seem to show the influence of the patient's cover story. Extraneous motives apparently influence patients' responses on some projective tests, and this should be recognized in evaluating

⁶ Dr. X. has made this point in a letter discussing our evaluation of the test reports. He wrote: "Dissembling is much more possible and likely in the Picture-Frustration and the Sentence-Completion tests than it would be on something more projective, say the Rorschach. Even in the T.A.T. it is very easy for an intelligent, noncooperative patient to dissemble."

them. The second observation is that a tester's interpretations may be influenced when he has access to facts presented in an initial interview with a patient. Since the conclusions on a test report are likely to be considered as independent judgments in diagnosis, the matter of such influence should be given careful consideration. We believe that the test report cannot be considered an independent confirmation of diagnosis unless the tester has *no* information except that proper to the tests themselves.

NEED FOR FURTHER STUDIES OF THE VALIDITY OF THESE TESTS

An unpublished study by Auld surveying the literature on the validity of these projective tests has called our attention to the inadequacy of the validating researches. There are relatively few studies of projective test validity that have utilized criteria that are pertinent to personality diagnosis and therapy, and only a few that have used as the criterion, information gathered in well-studied psychotherapy cases.

Tests of personality are valid if they predict the patient's behavior in critical life situations. To find out whether a test is valid, therefore, one must know how the patient behaves in these critical situations. The detailed and true-to-life picture of the individual that can be constructed from the data gathered and the behavior observed in the course of psychotherapy is a more faithful approximation of behavior in critical situations than accounts constructed from data gathered in most other situations. It seems unfortunate, therefore, that more use has not been made of detailed information from psychotherapy (not just case summaries) as criteria for test validation.

Psychotherapy provides a good criterion because the patient is offering himself for treatment—coming for help with his mental problems—and therefore has a strong motive to cooperate. The therapist uses this motive to help the patient give a complete and correct account of his behavior. Where the therapist believes the patient's story to be implausible or incomplete, he challenges it and asks the patient to re-examine it. The therapist insists on the rule of free association and, thus, the patient is compelled to utter all thoughts without restraint or selection. The therapist identifies resistant behavior and thereby helps the patient to talk about anxiety-laden topics.

Furthermore, the therapist sees the patient over a relatively long period. In brief psychotherapy this period is much shorter than in psychoanalysis, but it is nevertheless long, compared to the casual contacts psychologists sometimes have with patients. Over a long period of time a patient finds it hard to dissimulate. Finally, the patient's reactions to the therapist within the treatment sessions are themselves a piece of real-life data. Therapy is a critical situation which evokes characteristic modes of behavior, both conscious and unconscious.

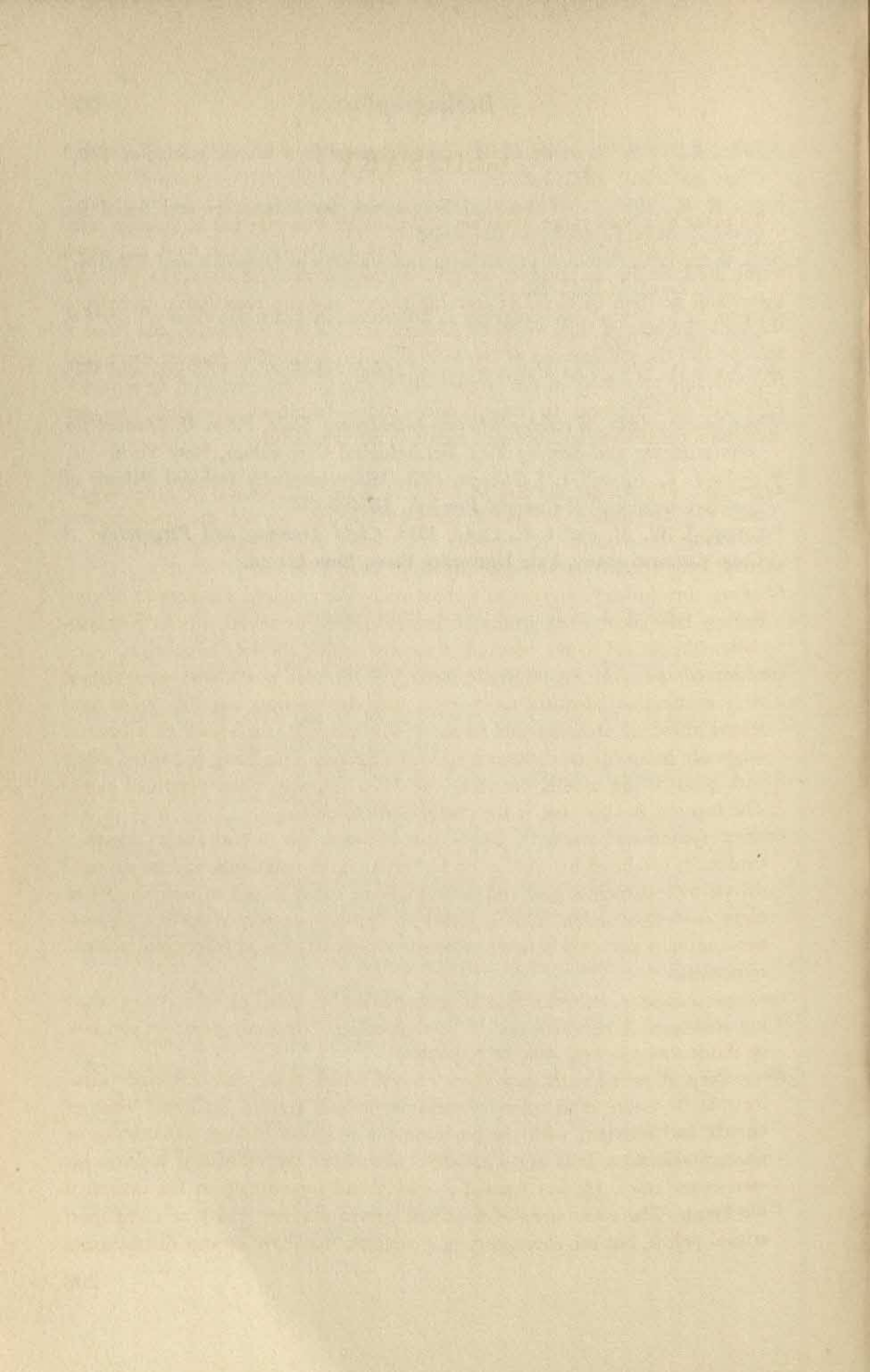
We have presented only one case and one set of tests made on that case. More such cases and independent test reports are essential before one can make a definite judgment concerning the degree of validity of these tests. In view of the lack of validity studies that are demonstrably pertinent to psychotherapy, we feel that the question of validity of projective tests has been prematurely settled. Further research, utilizing carefully studied psychotherapy cases as criteria, is urgently needed.

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GLOSSARY

To make this book more accessible to the reader who may not be familiar with technical psychological terms, we provide here a glossary of the most important terms used. So far as possible, we give definitions that are consistent with the theoretical position (a blend of learning theory and psychoanalysis) underlying the book. Because of this, we found Dollard and Miller's *Personality and Psychotherapy* and the publications of Dr. Neal E. Miller on conflict, learned drive, and fear valuable references in the preparation of the glossary. We wish to acknowledge our indebtedness to these sources. The definitions provided here are minimum definitions and are not meant to be exhaustive.

aggression. (1) An act the aim of which is injury of a person or other organism. (2) Opposition to another person, whether or not the goal-response following the sequence of opposing acts injures this person; self-assertion.

anxiety. Fear elicited by vague or unlabeled cues. (See *fear*.)

blocking. Involuntary stopping of verbalization. For example, a patient in psychotherapy falls silent when strong anxiety is aroused by sexual cues in free association; he is said to be "blocked" from continuing the free association.

conditioned stimulus. An originally ineffective stimulus which after presentation with a stimulus adequate to evoke a response becomes capable, when presented alone, of arousing this response. For example, the sound of a buzzer, originally incapable of eliciting a salivary response, after being presented along with food in the mouth, comes to elicit that response when presented alone. The buzzer, in this case, is the conditioned stimulus.

conflict (emotional conflict). Opposition between the incompatible response-tendencies produced by two drives. For instance, an individual may be strongly driven to approach a goal and as strongly to avoid it and so not be able to carry out either action. This is called an *approach-avoidance* conflict. Opposition can exist not only between different visible acts but also between internal responses.

conscious behavior. Behavior that is accompanied by verbal or other cue-producing responses. A person is said to be responding consciously when he can talk or think about drives, cues, or responses.

cover story. A set of statements about oneself which make one maximally comfortable. It is an explanation of behavior which gives a preferred view of oneself and relations with the environment and may conceal unflattering or unacceptable facts. It is not a conscious deception; the individual believes his own cover story. He has learned it slowly and unwittingly in the course of life events. The cover story of a normal person matches reality at all or most critical points, but the cover story of a neurotic may have serious discrepancies

which indicate that he is acting on an unrealistic or contradictory concept of self and the environment. Even the cover story of the neurotic, however, has some truth to it; it is not wholly false. In psychotherapy a patient has a chance to change his cover story because it can be challenged if it is at odds with real events.

cue. A stimulus that determines when and where a person will respond and which response he will make. An example of a stimulus that functions primarily as a cue is the dinner bell that signals hungry farm workers to come in for dinner. Similarly, an internal state may have a selective effect (or cue function). A person learns to describe his feelings with one word, "angry," when frustrated and another word, "afraid," when in danger.

discrimination. A differential response to two patterns of cues which differ qualitatively or quantitatively. A discrimination may gradually be learned if the response to one pattern of cues is rewarded and the response to a different pattern of cues is not rewarded or is punished. The process of discrimination makes the cue-response connection more specific and corrects maladaptive generalizations. If the two patterns of cues are too similar, a discrimination cannot be learned.

displacement. Occurrence of a generalized response when the habit of responding to an original stimulus is prevented either by absence of this stimulus or by a learned avoidance of it. For instance, a mother may cherish a dog excessively after her baby's death (removal of the original stimulus) or a man may redirect unconscious hate of his father to his employer (learned avoidance; anger toward the father may be inhibited by fear). Displacement may occur not only from one external object to another but also from one drive to another if the stimulus patterns of the different drives are similar enough so that generalization occurs. For example, a person may eat excessively because of unsatisfied sex drive.

drive. A strong stimulus which impels action. Any stimulus that is strong functions as a drive; the stronger the stimulus, the stronger the drive. *Primary drives* are innate stimuli that are believed to provide the origin of all motivation. They include at least pain, thirst, hunger, fatigue, and sex. *Learned drives* are learned on the basis of primary drives. When, through learning, previously neutral cues gain the capacity to function as primary drives do, these cues are said to have *learned drive* value. Examples of learned drives are appetites for special foods, sex fetishes, gregariousness, the drive to be logical, and the desire for money or status.

Ego. The conscious self—that part of the personality which is in contact with the environment through the senses. The autonomous or self-directive drive is involved in the Ego. Learned drives to be logical and to give oneself a realistic account of behavior are aspects of the Ego.

emotion. A response-produced stimulus having the properties of a drive or of a

- reward. A strong response-produced stimulus acts as a drive; a response of relaxation acts as a reward. Because emotion is response-produced, it is necessarily within the individual. Thus, overt acts are not considered emotional responses. Emotional responses may or may not be labeled by the individual.
- extinction*. The progressive decrease in the strength of a tendency to perform a certain response which is learned by the lack of reinforcement. That is, extinction (or *experimental extinction*) is the weakening or abolition of a habit by repeated presentation of the cue without concurrent reinforcement.
- fear*. An anticipatory emotional response to pain or other traumatic stimuli.
- free association*. The psychoanalytic technique of requiring the patient to say without suppression or revision all words and sentences just as they occur to him during the analytic hour.
- frustration*. The interference, interruption, or complete prevention of the occurrence of a goal-response at its proper time in a behavior sequence. That is, frustration is the interruption of a sequence of behavior leading to a desired end. Frustration would be said to occur if food were snatched from the hand of a hungry man just as he was about to eat it.
- generalization*. The tendency to make the same response to different stimuli. Reinforcement for making a specific response to a particular pattern of cues strengthens the tendency for other similar patterns of cues to evoke the same response. The more similar the cue or pattern of cues, the more generalization. For example, a child scratched by one cat is afraid of other animals and more afraid of other cats than of dogs. A patient who has strong habits of dependency in relation to his father generalizes (or *transfers*) these habits to his therapist and expects the therapist to be overprotective.
- goal-response*. The act performed upon reaching a desired end or goal. For instance, when a hungry man succeeds in getting food he can perform the goal-response of eating; when a sexually motivated person has intercourse, he can perform the goal-response of orgasm.
- inhibition (overt inhibition)*. The prevention of instrumental acts by strong conflicting unconscious responses; that is, by responses that are not under verbal control. Inhibition is distinguished from *restraint*, produced by conflicting responses that are under verbal control. For instance, a patient is said to be sexually inhibited when because of competing fear responses he is unable to perform normal sexual responses. Inhibition differs from *repression* in that the latter refers to stopping thinking rather than to stopping of overt responses, but both repression and inhibition are likely to be taught by the same social conditions.
- interactive episode*. An incident in the course of psychotherapy beginning when the therapist notes evidences of distortion or incompleteness in the patient's account and ending when the patient brings out new facts or makes new emotional responses. (See the discussion in Chapters 2 and 7 of this book.)

interpretation. An intervention by a therapist in which he labels the patient's responses or offers an explanation of behavior. That is, the therapist may respond to a communication from the patient by evaluating it and pointing out the motives behind it. Interpretation is distinguished from *intervention* in that the latter is a broader term, including not only explanations of behavior but also any other actions that influence the patient.

intervention. An action by a therapist that influences a patient. Usually an intervention consists of a comment or question by the therapist. Selective repetition by the therapist of some of the patient's statements also is an intervention because this act focuses the patient's attention on these statements. But an intervention need not be a verbal statement or interpretation. When a patient expects his remarks to be received with strong disapproval, the therapist's accepting silence acts as an intervention because this indication of permissiveness directly influences the patient's behavior. A mere nod of approval may be an intervention because it serves as a reward which reinforces the approved behavior.

label. To attach a verbal response to a cue or pattern of cues. In psychotherapy, the patient is taught to label, i.e., to give a name to or describe by a sentence, behavior that has previously been unlabeled—i.e., unconscious.

learning theory. A general scientific explanation of changes in behavior that result from learning. *Stimulus-response learning theory* is an explanation in terms of stimulus and response. A *reinforcement learning theory* postulates that reinforcement (reward) is a necessary condition for learning. The viewpoint expressed in this book is that of a stimulus-response, reinforcement learning theory.

neurosis. A learned behavior disorder, the product of unsatisfactory mental habits. A neurosis is characterized by strong conflicting drives (which make the person miserable), by responses that are ineffective in completely reducing these drives (symptoms), and by an inability to use the higher mental processes adequately in some areas (stupidity due to repression). The term neurosis is appropriate only when there is no serious disorganization of personality. Hospitalization usually is not required with neurotic disorders.

phobia. Unconscious generalization of very strong fear responses from an appropriate stimulus to some substitute stimulus.

projection. The tendency to attribute to another person motives that are really within oneself. For instance, a person who has been punished for expression of his anger may fail to label his own angry feelings but instead attribute them to someone else. He thereby avoids blaming himself for the anger.

projective test. A psychological technique for the diagnosis of personality by utilizing the person's responses to relatively unstructured stimuli. A projective test gives the person taking it no prepared set of answers from which to choose and few clues as to what kinds of answers are "good" or "bad." Since the test

gives no clear clues as to what answers are expected, it is assumed that the testee in deciding how to respond must act in accordance with his own predispositions. Hence it is assumed that the testee's choice of response reveals what kind of person he is.

psychosis. A serious disorder of behavior. Usually a psychotic person cannot take care of himself or is dangerous to others. Psychotic symptoms include: inability to respond to environmental or internal cues in ways that society considers appropriate; inability to respond to other persons in a way that society considers mature and appropriate; adoption of childish habits for reducing drives; lack of restraint of indecent erotic and violent hostile responses; serious disruption of mental (i.e., verbal cue-producing) habits.

psychotherapy (therapy). The treatment of behavior disorders by psychological methods so as to create "normality." That is, psychotherapy consists of techniques by which a therapist teaches the neurotic person new mental habits that lead to a reduction of emotional conflict and, in the long run, to greater satisfactions in life.

rationalization. A rational, acceptable justification of behavior that is determined by unconscious (and therefore incorrectly labeled) motivations. Because of the learned drive to have a logical explanation of one's behavior, there is a tendency to justify all behavior on the grounds of reason or logic, even though the behavior may have been instigated unconsciously. Thus a person may excuse himself for unwitting acts which he would not consider justified if he recognized the real drives involved.

reaction-formation. The development of a response pattern which is the exact opposite of an unacceptable, unconscious motive and thus conceals this motive. For instance, a person may conceal impulses of aggression and cruelty by the expression of sympathy. A father may act with overt cruelty to a daughter with whom he is, unconsciously, in love. The concealment of true motivation occurs automatically and without accompanying verbal description.

reflection. Repetition or paraphrase by the therapist of the patient's sentences. The therapist tries not to indicate his own attitude but, instead, to understand the patient's feelings and to show the patient that he understands.

reinforcement. A more technical term for "reward." (See *reward*.)

repression. The automatic blocking of thought and memory; that is, the inhibition of verbal cue-producing responses. Because repression occurs automatically, it is not under verbal control. Repression prevents planned action but does not prevent unreasoned responses to drives and cues. (See *suppression* and *inhibition*.)

resistance. Responses that maintain repressions and other mental habits that are opposed by the therapy. Resistance often appears in the form of a failure by the patient to communicate his thoughts freely.

response. Any activity which results from stimulation. Some responses are *instru-*

mental acts which serve to produce an immediate change in relation to the external environment, such as lighting a match or closing a door. Other responses are *cue-producing*; that is, they serve to produce a cue that is part of the stimulus pattern leading to another response. Counting is a cue-producing response. One may count money in order to produce the cue that will lead to the instrumental act of paying the price for the goods purchased. Verbal cue-producing responses (such as counting) may be either spoken or silently thought. The psychological laws governing the internal processes involved in silent cue-producing responses (i.e., thoughts) are the same as those governing external responses such as speaking aloud.

response hierarchy. The arrangement of responses in their probability of occurrence is the *initial hierarchy of responses*. Learning changes the order of the responses in the hierarchy. Through learning, a rewarded response, though it may have been initially weak, comes to occupy the dominant position—that is, becomes the response most likely to occur. The new hierarchy produced by learning is called the *resultant hierarchy of responses*.

reward. Any reduction in drive. If a person is driven by hunger and gets food, the food is a reward because it reduces the strength of his hunger drive. Food for a hungry person would exemplify a *primary reward*. But most rewards in adult human behavior are *learned*. When a child has learned to value money, it may serve as a learned reward for him. When a person has learned to seek companionship of other people, being alone can be motivating; then the finding of another person may be a learned reward for him. A reward (or reinforcement) strengthens the tendency for a response to be repeated.

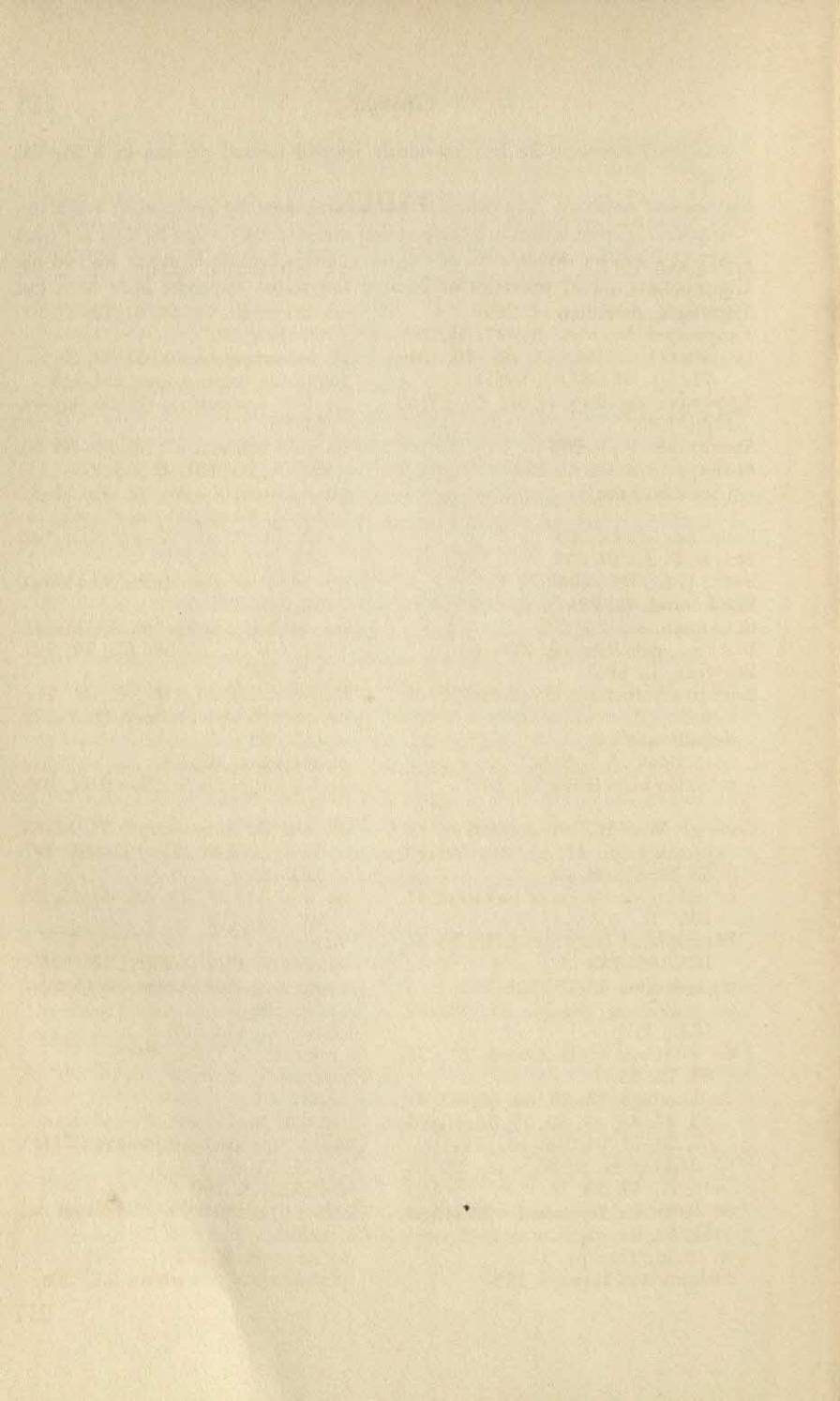
suppression. The deliberate and conscious stopping of thinking and avoiding of remembering. It is elicited by verbal cues (in contrast to *repression* which is not under verbal control). Because suppression is under control of the higher mental processes, it can be highly selective and easily reversible. (See *repression* and *inhibition*.)

symptom (neurotic symptom). An overt response pattern that indicates the continuing presence of an unresolved conflict of drives. The neurotic symptom (or habit) persists because it partially reduces a drive or drives even though it does not resolve the conflict. Examples of neurotic symptoms are: phobias, inhibitions, and compulsions.

transference. A pattern of inappropriate emotional responses which is generalized by a patient to a therapist. (Generalized responses which are appropriate are not called "transference.") These transferred responses were originally learned in childhood in relation to parents and siblings (or their surrogates). A large part of transferred responses have never been labeled so the patient cannot speak or think about what he is feeling. The patient fears, hates, or loves without being aware that he is doing so. He generalizes unwittingly to the therapist

emotional responses he had previously learned toward persons in a familial role.

unconscious behavior. Any behavior not accompanied by appropriate verbal responses. A person is said to be responding unconsciously when he does not have correct labels for drives, cues, or responses, either because he never learned the appropriate verbal responses or because the verbal responses have been lost through repression.



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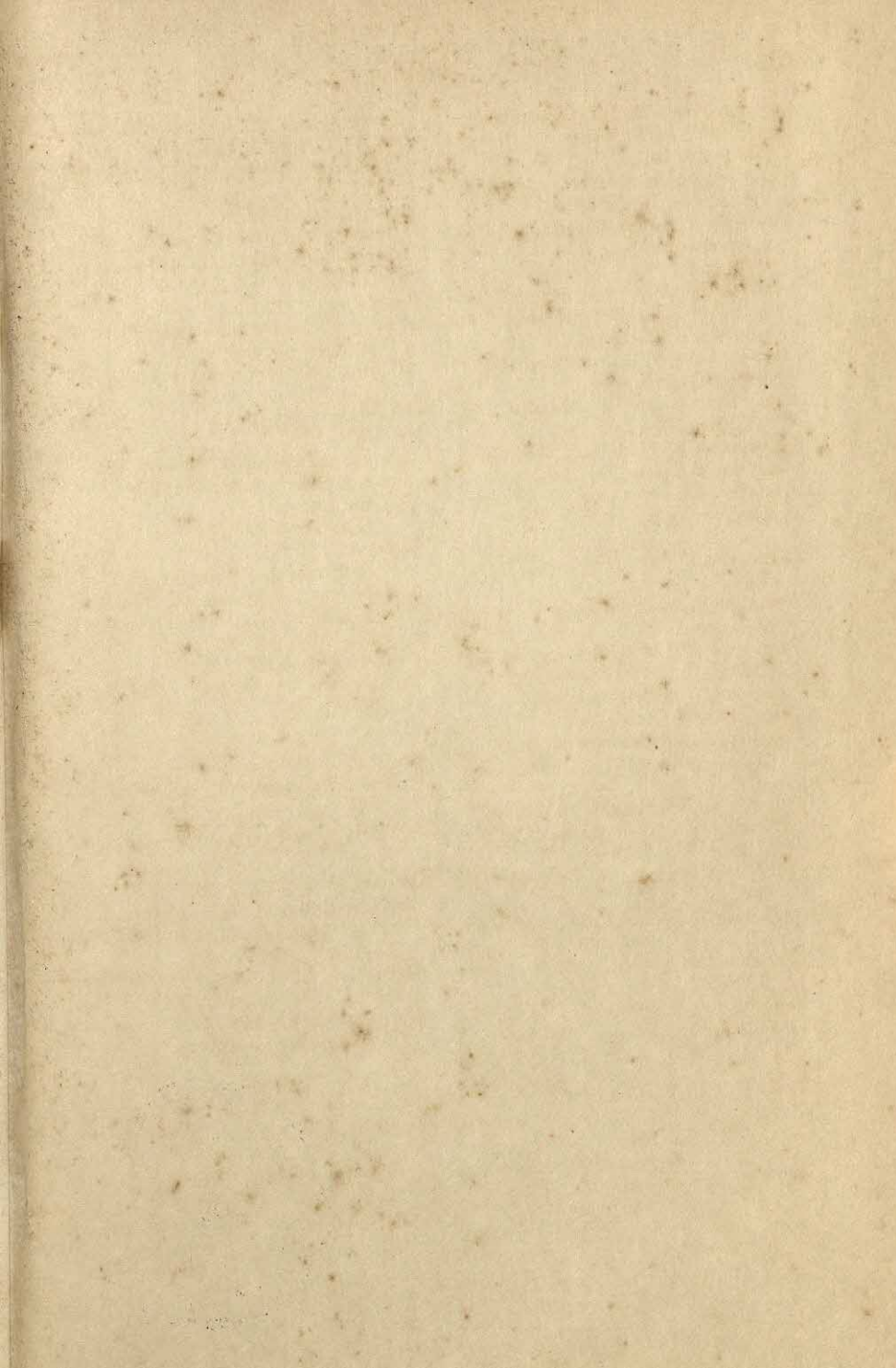
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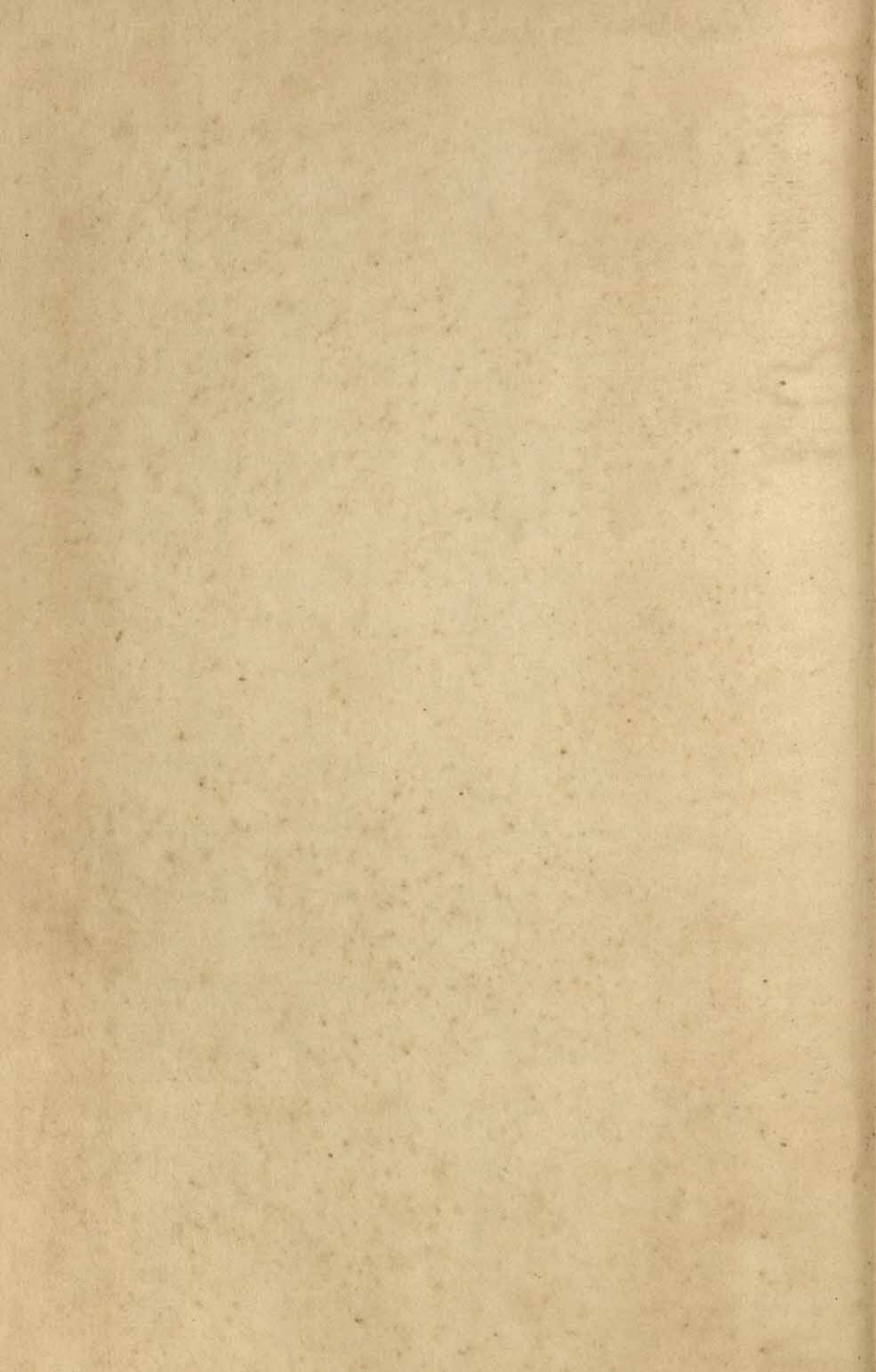
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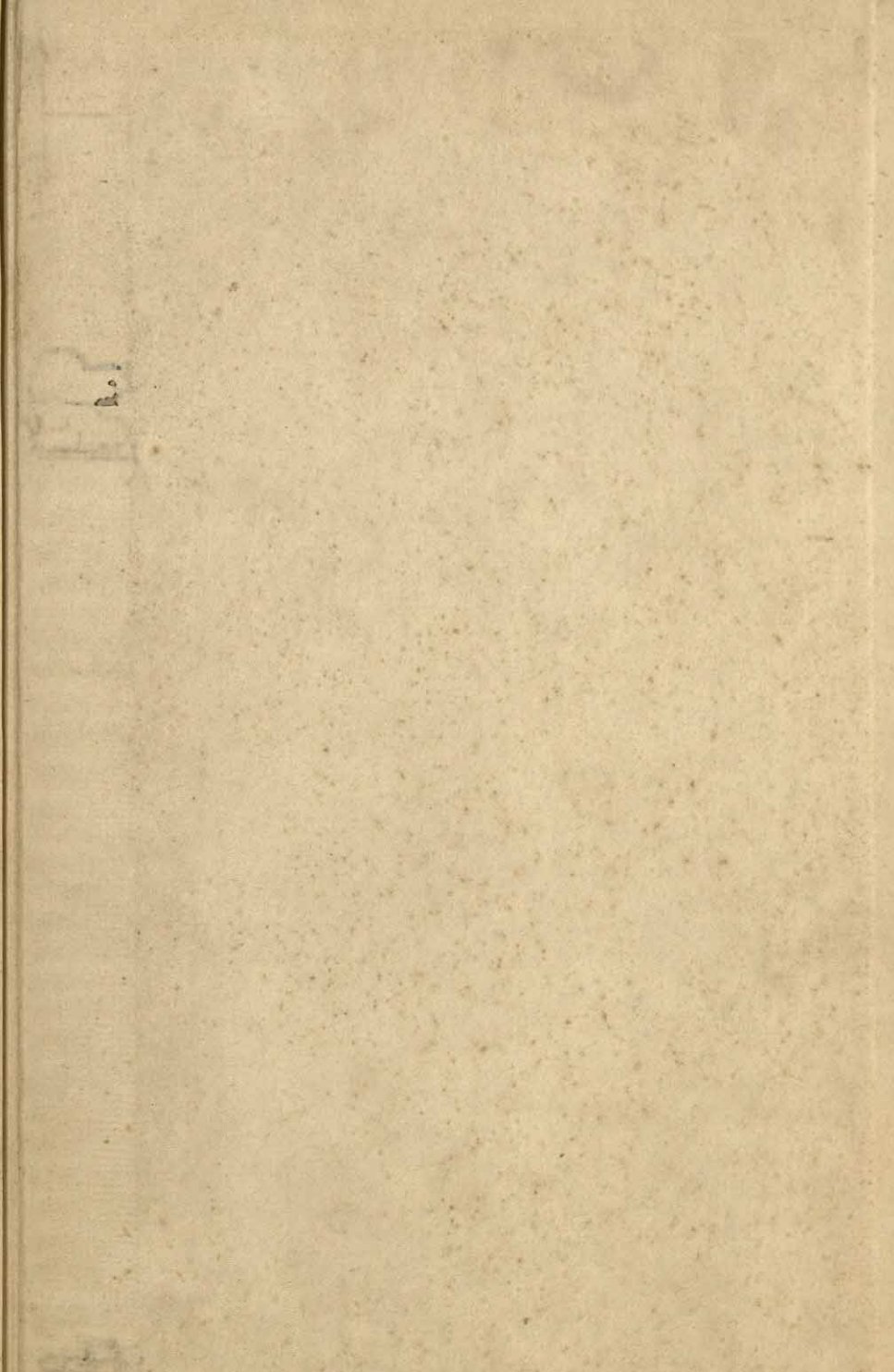
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